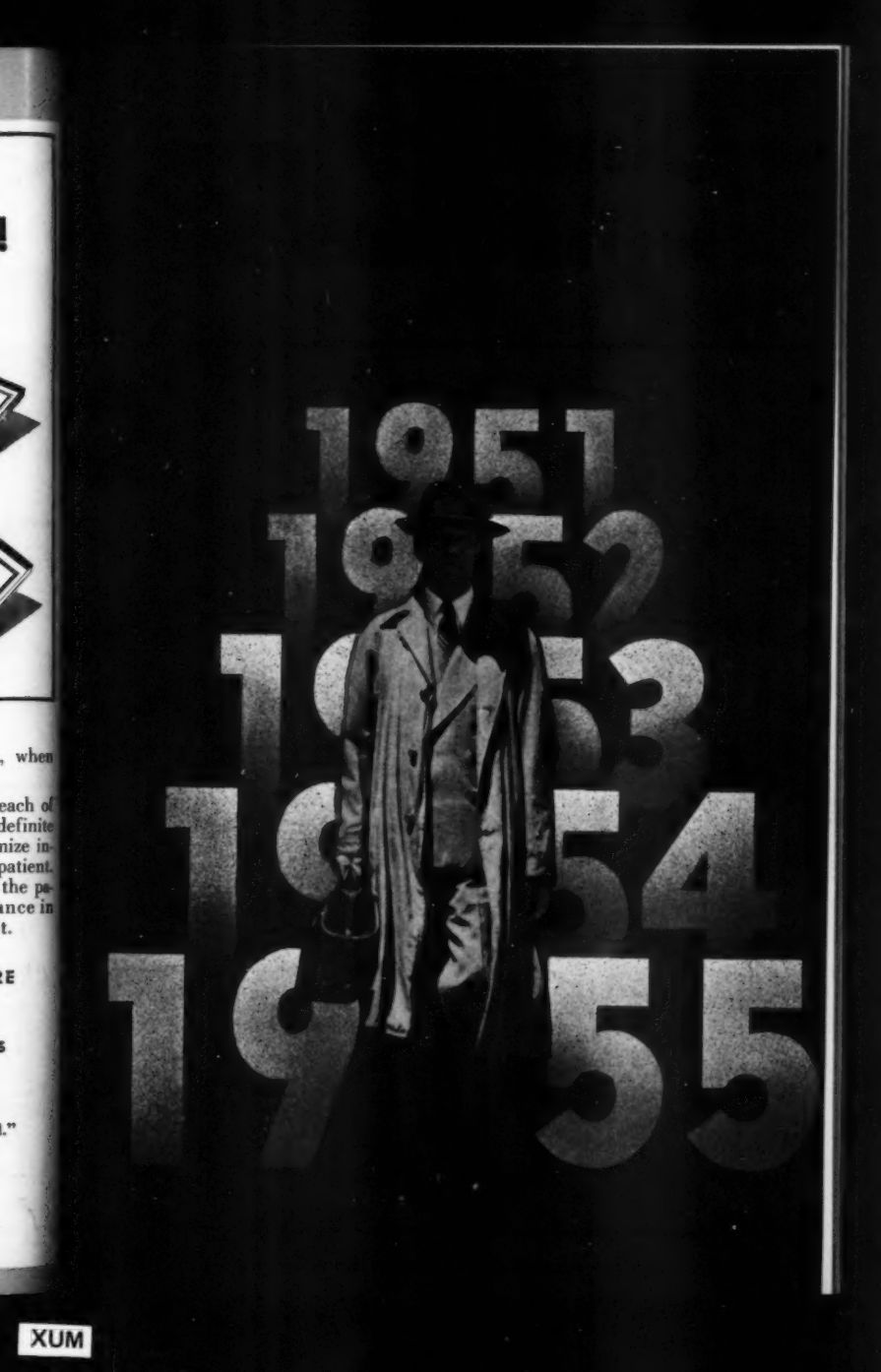

1951
1952
1953
1954
1955

Exhausting cough goes...

Beneficial cough reflex stays...

MERCODOL provides prompt, selective relief that doesn't interfere with the cough reflex needed to keep throat passages and bronchioles clear.

This complete, pleasant-tasting prescription contains a *selective* cough-controlling narcotic[1] that doesn't impair the beneficial cough reflex . . . an effective bronchodilator[2] to relax plugged bronchioles . . . an expectorant[3] to liquefy secretions. Remarkably free from nausea, constipation, retention of sputum, and cardiovascular or nervous stimulation.

MERCODOL®

THE ANTITUSSIVE SYRUP THAT CONTROLS COUGH—*KEEPS* THE COUGH REFLEX

An exempt narcotic

MERCODOL with DECAPRYN®
for the cough with a specific allergic basis.

Merrell
1828
CINCINNATI • U.S.A.

Each 30 cc. contains:

[1] Mercodinone®	10.0 mg.
[2] Nethamine® Hydrochloride	0.1 Gm.
[3] Sodium Citrate	1.2 Gm.

Medical Economics

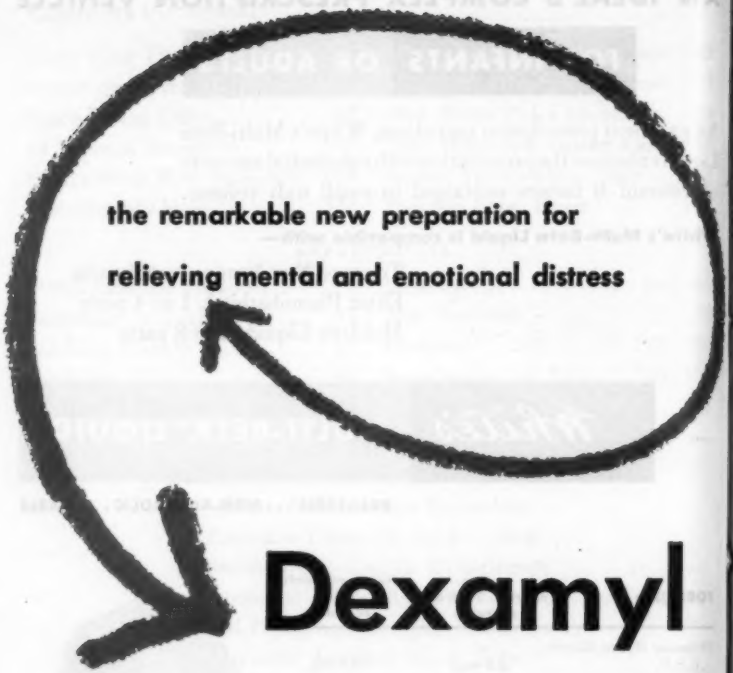
* * * *January 1951* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

CCA MEDICAL ECONOMICS, January 1951 issue, published monthly by Medical Economics, Inc., 210 Orchard Street, East Rutherford, N.J. Copyright 1951. 25c a copy, $3.00 a year (Canada and foreign, $3.50). Acceptance under Section 34.64, PL&R authorized. Circulation: 131,000 physicians and residents. ☆ PICTURE CREDITS: (left to right, top to bottom) Cover, 56, Harris–Pix; 61, Acme; 69, Cal-Pictures; 74, Hopwood, Miami Herald; 75, Gisler; 82–85, Ben Schnall; 91, Warren; 131, Revere; 135, Cowdery–Magnetic Recording, Dictaphone; 139, Crescent, Webber–Gray; 181, John Dominis. NBP



In 'Dexamyl'*, the two components—'Dexedrine'* and Amobarbital, Lilly ('Amytal'†)—work together synergistically to ameliorate mood; to relieve inner tension; and thus to control troublesome symptoms of mental and emotional distress:

The 'Dexedrine', because of its "smooth" and profound antidepressant action, restores mental alertness and optimism and dispels psychogenic fatigue.

The Amobarbital (Lilly), because of its calming action, relieves nervous tension, anxiety and agitation.

Widely useful in everyday practice, 'Dexamyl' tablets are available, on prescription only, in bottles of 100 and 1000.

Each tablet contains 'Dexedrine' Sulfate (dextro-amphetamine sulfate, S.K.F.) 5 mg. and Amobarbital (Lilly) ½ grain (32 mg.).

*Trademark, S.K.F. †Trademark, Lilly

Smith, Kline & French Laboratories, Philadelphia

Memo from the Publisher

• The No. 1 occupational hazard of publishing (and you won't hear much about it from most publishers) is the law of libel. It's encountered periodically by any magazine that likes to print facts as it finds them. MEDICAL ECONOMICS is no exception.

What is libel? It may be any printed statement exposing a person to public ridicule or contempt. Suppose we quoted some physician as saying, "Oscar X is a rascal." Suppose Mr. X decided his reputation had thus been impaired. To ward off a libel judgment, we'd have to be able to prove (1) that the statement itself was demonstrably true; and (2) that we printed it without malice. To be able to prove a fact legally is, of course, far different from merely knowing it to be true.

This is obviously an expert's domain. Which explains the presence on our consulting staff of our own legal expert. He is Isaac W. Digges, counsel to such other magazines as Good Housekeeping and Printers' Ink, and a nationally-known authority in the field.

He takes over when a controversial article is almost ready to run. Under his direction, our facts are weighed for legal validity; dubious statements are challenged and changed. Only after this screening

ESTABLISHED INDICATIONS:

Collagen diseases or connective tissue diseases, such as rheumatoid arthritis, rheumatic fever, acute lupus erythematosus; hypersensitivities, such as severe asthma, drug sensitivities, contact dermatitis; most acute inflammatory diseases of the eye; acute inflammatory conditions of the skin, such as acute pemphigus and exfoliative dermatitis; inflammatory conditions of the intestinal mucosa, such as ulcerative colitis; and metabolic diseases, such as acute gouty arthritis and secondary adrenal cortical hypofunction.

. . hours

Reversal of heretofore intractable diseases beginning within hours after instituting ACTHAR therapy, is the culmination of years of intensive research by The Armour Laboratories, together with independent investigators.

ACTHAR, the first adrenocorticotropic hormone made available to the physician, represents the physiologic stimulus for the adrenals to produce and discharge the complete spectrum of cortical hormones.

Virtual absence of cumulative effects permits precise, yet flexible, dosage schedules. The exclusive utilization of physiologic mechanisms for its powerful therapeutic action furthermore contributes to the clinical safety of ACTHAR.

Literature and directions for administration of ACTHAR, including contraindications, are available on request.

ACTHAR is supplied in 10, 15, 25, 40 and 50 mg. vials, in packages of 10 and 25 vials.

ACTHAR

Armour Laboratories Brand of Adrenocorticotropic Hormone (A.C.T.H.)

THE ARMOUR LABORATORIES

CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIOCHEMICAL RESEARCH

is complete will you find the piece in M.E.

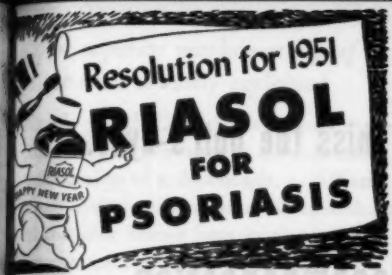
What sort of articles require this treatment? A recent example was our story about the Association of Internes and Medical Students—"Leftist Minority Woos Future Doctors." It touched on the double-edged issue of Communism; hence the need for a libel check. By throwing out all undocumented facts, we were able to bring you an unassailable report on AIMS' activities.

A story of another color, back in 1935, was called "A Fortune in Goat Glands." Soon after we published the piece, its subject threatened suit. After some diverting exchanges, the libel issue was settled by our publishing a rebuttal from his lawyer. Our article had said, for example: "In New York's Central Park he sliced the testicles off an unsuspecting goat." The lawyer's injured retort: "The locale was *not* Central Park."

Another M.E. expose dealt with unethical collection agencies. Four firms were mentioned by name; one threatened a libel action. Our editors declined to back down. Upshot: a compromise letter-to-the-editor, explaining that the firm had been newly reorganized.

Why do we bother with such articles? If they're bound to stir up trouble, why not just forget them? The answer lies in our conviction that such stories are a real service to readers. They supply cold facts on hot subjects. Of such stuff are the best editorial menus made.

—LANSING CHAPMAN



Many a doctor has resolved to get better results in psoriasis by treating every case with RIASOL. Clinical statistics show an index of 76% improvement with RIASOL.

The red, scaly patches of psoriasis usually disappear by rapid stages under local treatment with RIASOL

First, the round and oval areas clear up in the center.

Second, healing spreads from the center toward the periphery of the lesions.

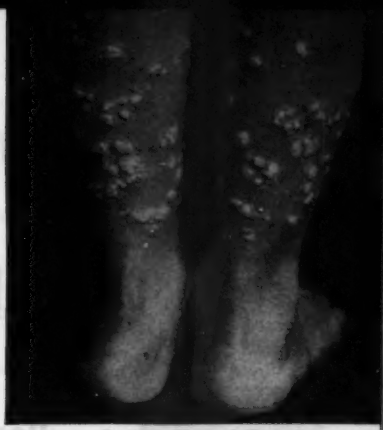
Third, the scales disappear, leaving only residual redness.

Finally, the discoloration fades, leaving the skin of normal appearance.

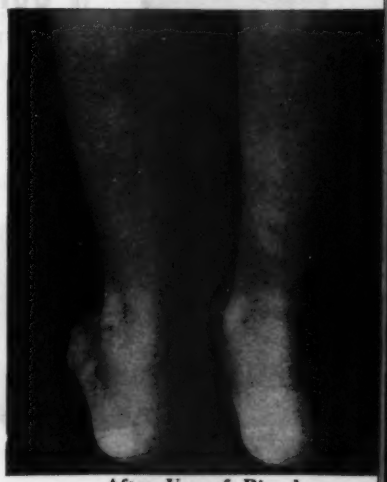
RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible, economical film suffices. No bandages required. After one week, adjust to patient's progress.

Ethically promoted RIASOL is supplied in 4 and 8 fld. oz. bottles, at pharmacies or direct.



Before Use of Riasol



After Use of Riasol

MAIL COUPON TODAY—TEST RIASOL YOURSELF

SHIELD LABORATORIES ME-1-51

12850 Mansfield Ave., Detroit 27, Mich.

Please send me professional literature and generous clinical package of RIASOL

.....M.D. .....Street

City .....Zone.....State..... .....

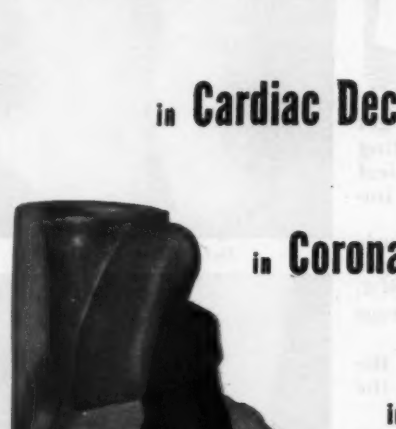
Druggist .....Address.. .....

RIASOL FOR PSORIASIS

XUM

Don't hit the target and miss the bull's-eye...

in Cardiac Decompensation



in Coronary Disease

in Hypertension

Such is the story of usual xanthine therapy in cardiovascular syndromes. Symptoms are relieved, but at the cost to the patient of distressing side effects.

Maltbie Laboratories, Inc., *Newark 1, New Jersey*

The superior marksmanship of Calpurate is easily explained

Briefly stated, Calpurate is calcium theobromine plus calcium gluconate in the intimate relationship of a double salt, as different from a mechanical mixture of these drugs as is the alloy bronze from its components, copper and tin.

Calpurate is a new chemical entity, a new and superior xanthine drug, for longer-lasting, trouble-free therapy in cardiac decompensation, coronary disease and hypertension.

Calpurate hits the bull's-eye!

A glance at the polarized photomicrographs shows the difference between Calpurate and mechanical mixtures of calcium theobromine and calcium gluconate. At the top, rectangular crystals of theobromine. In the middle, needle-like crystals of calcium gluconate. And at the bottom—Calpurate, identified by its distinctive hexagonal crystalline formation.

The clinical picture is equally convincing. You will be impressed by the superior clinical performance of Calpurate, "the double salt with the triple use."

Administration and Dosage: 1 or 2 tablets t.i.d.

Calpurate

• Tablets and Powder

Theobromine Calcium Gluconate Maltbie

Calpurate

with **Phenobarbital** • Tablets

WITH A *Ritter* ENT UNIT

As a busy physician you can conserve your energy, yet serve more patients with a Ritter ENT Unit . . . designed especially to help you utilize your skills more thoroughly. You can treat patients without moving from the chair. A stretch of the arm brings air, water, vacuum, electricity, or waste into immediate use. Equally accessible are spray bottles, medicaments and low voltage instruments. Diagnostic and treatment time is kept to a minimum . . . with patients more at ease. Low voltage instruments are properly angled for easy grasp.

Then, too, there is a Ritter ENT Unit to fit your favorite operating technique. The Ritter cuspidor can be on the right or left as part of the unit, or, as a separate piece of equipment. Ritter ENT Units are made to position at either right or left of the chair.

Start now to enjoy the advantages of a Ritter ENT Unit best suited to your technique.

FOR ADVANCED EQUIPMENT LOOK TO **Ritter**
COMPANY INCORPORATED
RITTER PARK, ROCHESTER 3, N. Y.

Choose the UNIT to fit your technique

Model MA, Type 1, swinging cuspidor at right of chair.

Model MB, Type 2 Unit, at left, surgical cuspidor at right of chair.

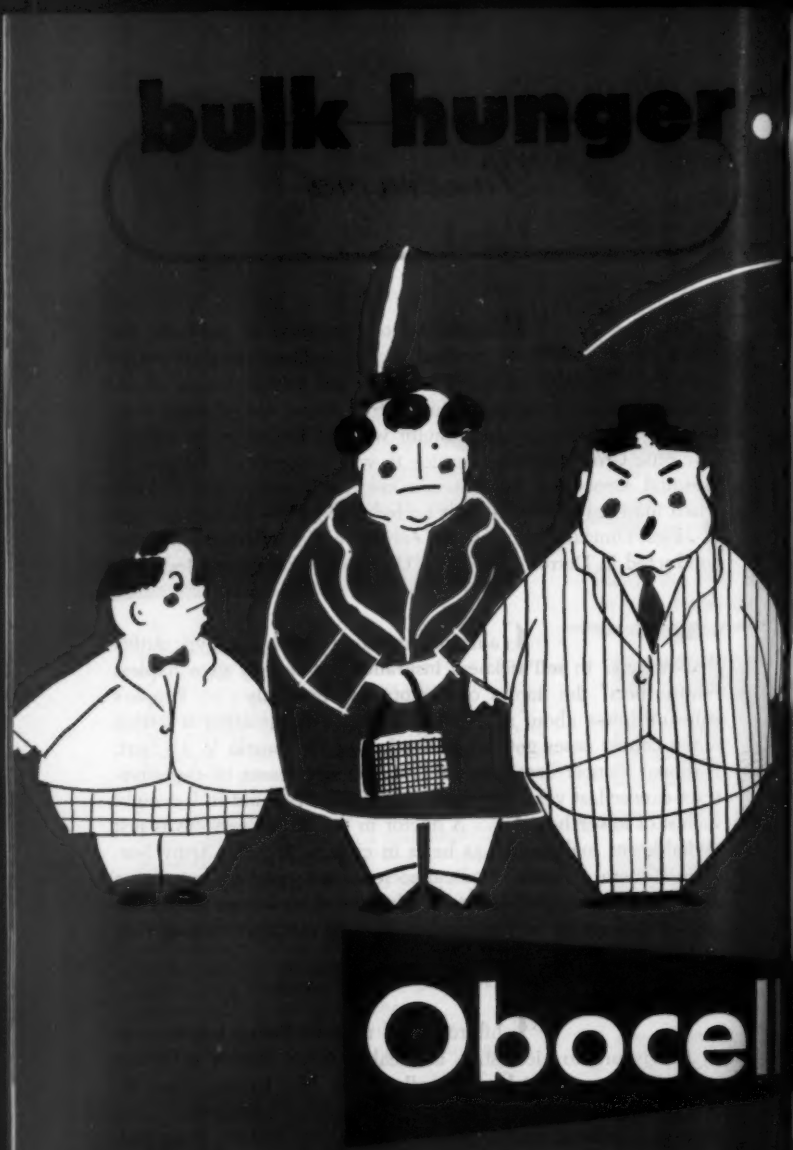
Model MB, Type 1 Unit, at right, surgical cuspidor at left of chair.

Panorama

Plagued by old question of publicity vs. ethics, New York State medical society is liberalizing its ethics code . . . Dr. William Mayo married, and in Las Vegas, of all places! California newsmen on his trail found out, though, that *this* Dr. Mayo was a chiropractor without Rochester affiliations . . . Blue Cross adjusting service to war dislocations. Pittsburgh Hospital Association, for instance, keeps wife and family covered when man enters service, but excludes him—thus reducing rates . . . First clinical seminar based entirely on use of color television conducted in Detroit by Wayne University College of Medicine.

California cracking down on gyp outfits that pretend to sell sickness insurance but merely give hapless "subscribers" the names of doctors and hospitals . . . People's squeamishness about submitting to rectal examination is letting many cancer cases get out of hand, says Dr. Austin V. Deibert, National Cancer Institute. Of 101,000 new cases of digestive-tract cancer last year, he reports, 40,000 were found in last eight inches of lower bowel . . . A doctor in the armed services is just as liable for malpractice as he is in civilian life, the Army Surgeon General stresses. Medical societies are pointing out that a man may be responsible for certain acts of his locum tenens too —good reasons for service doctors to keep malpractice insurance in force.

Children from all over Pennsylvania came to Harrisburg to view state medical society's display of health posters, some of which were collected in fifty foreign countries . . . Arthritics cautioned against expecting permanent cures through cortisone and ACTH by new Public Affairs Pamphlet, "Arthritis—and the Miracle Drugs." It tells, in layman's language,


bulk hunger
Obocell

• the neglected factor in Obesity

Because of a twin torment, obese patients on a reducing regimen sooner or later succumb to the intense desire for food:

1. *They love to eat and crave more food for the sake of eating (excessive appetite).*
2. *They experience real, gnawing hunger and crave more food to dispel the sense of emptiness (bulk hunger).*

To depress or curb the appetite, by therapeutic means, is simply not enough . . . it leaves bulk hunger unsatisfied and the patient continues to overeat.

OBOCELL is based upon the newer concepts of hunger and appetite mechanisms. Each tablet supplies dextro-amphetamine phosphate (5 mg.), the most potent agent to curb the appetite[1]. . . *plus* methylcellulose (150 mg.), an indigestible, non-nutritive bulking agent of proven superiority in suppressing bulk hunger.[2] OBOCELL contributes bulk residue lacking in obesity diets and elevates the mood. OBOCELL safely guides the obese patient through the psychologic hardship of a reducing regimen . . . *with predictable weight loss.* Supplied in bottles of 100, 500, 1000 at prescription pharmacies everywhere.

(1) Albrecht, F. K.: Ann. Int. Med. 21:983, 1944; (2) Hoelzel, F.: Am. J. Dig. Dis. 14:401-404, 1947.

LITERATURE AND SAMPLES ON REQUEST

combined hunger and appetite depressant

IRWIN, NEISLER & COMPANY Dept. ME **DECATUR, ILLINOIS**

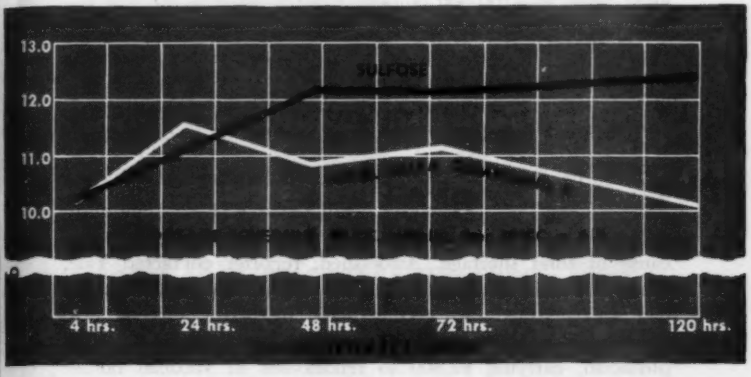
what medicine is doing to rehabilitate sufferers . . . AMA Board of Trustees, backing stand of its Committee on Blood Banks, says mass typing is costly and hazardous to public. But Dr. A. C. Ivy, of Chicago Civil Defense Organization, emphatically disagrees. "Cost," he says, "is a trifle compared with the number of lives to be saved" . . . Korean war may have profound effect on military medicine; Army elated over magnificent work done by M.D.'s (some with only three days' indoctrination) in reducing deaths from wounds to one-fourth those of World War II.

Left-leaning Association of Internes and Medical Students (AIMS) forced to cease publishing its journal, The Interne, because "AMA has put so much pressure on our advertisers that they have withdrawn their ads." Only advertiser left at end was U.S. Army recruiting office . . . Its "triple play" team is pride of San Francisco (Calif.) Medical Society: Dr. John W. Cline is president-elect of AMA; Dr. Anthony J. J. Rourke is president-elect of American Hospital Association; Dr. William P. Shepard is president of American Public Health Association.

Ex-convict from Brooklyn, N.Y., with yen for hospital bed, tried phony Blue Cross card on five hospitals in New Jersey, New York, and Connecticut, wound up on jail cot . . . Snooty hotel personnel, so often a pain to conventioneers, draws editorial fire of Northwest Medicine. Journal says that if the Sun Valley management persists in its "public-be-damned" attitude, Idaho State Medical Association meetings will be held elsewhere . . . Strong opposition to compulsory sickness insurance or "any system of political medicine designed for national bureaucratic control" voiced by Dairymen's League, nation's largest (26,000-member) cooperative, centered in New York, New Jersey, Pennsylvania, Connecticut, and Vermont.

Fee-happy British dentist, asked to pull woman's tooth, put her under gas and extracted twenty-three—all she had left. Bill of $294 was indignantly rejected by National Health Service . . . Lions—fifty of them—went to work on country-shy New Yorker, Dr. Clifford Seidel, got him to hang

A New and Better Triple Sulfonamide Suspension that provides higher, sustained blood levels



A comparison of blood sulfonamide levels on equal doses of SULFOSE and a control preparation having the same sulfonamide composition.

SULFOSE *contains sulfadiazine, sulfamerazine and sulfamethazine suspended in a unique, flavored vehicle containing a special alumina gel.*

- Unusually palatable
- Stabilized suspension—won't separate
- Easy to measure—pours freely

Each teaspoonful (5 cc.) contains 0.5 Gm. total sulfonamides—0.167 Gm. each of sulfadiazine, sulfamerazine and sulfamethazine.

SUPPLIED in bottles of 1 pint.

SULFOSE®

TRIPLE SULFONAMIDE SUSPENSION

WYETH Incorporated, Philadelphia, Pa.

Wyeth®

shingle in Duncanville, Tex. (pop., 853). Dr. Seidel says the Lions (cousins to Rotary, Kiwanis) are supersalesmen . . . Another country doctor, Dr. William A. Steele of Havana, Ill., who has practiced fifty-four years, says he once became dissatisfied with standard automobiles and built his own. He drove it for eight years and 100,000 miles . . . After blood, bone, and eye banks, trachea banks may be next. They're now believed feasible, researchers have told American College of Surgeons . . . Busy at operating table, Dr. W. H. Cartmell, Maysville, Ky., glanced up, saw stranger entering locker room. He continued surgery, investigated later, found $1,000 missing from coat.

Reporter heard Oscar R. Ewing tell audience that Yale Medical School had considered closing doors because of fund shortage. Astonished, reporter contacted Yale, found it equally astonished at news . . . G.I. in Tokyo hospital had shell-smashed face reconstructed by plastic surgeon who used soldier's photo, mailed by mother, as guide . . . Utah physician, carrying $9,800 to rendezvous in Mexican border town of San Ysidro, in hope of sharing "hidden fortune," read in paper of time-worn hoax, returned home with cash intact . . . Defense Department clinging to its old ratio of six doctors per 1,000 men, despite demand for 3.5 ratio by its medical services' director, Dr. Richard L. Meiling. He says old ratio overloads military service, strips civilian population . . . Largest Blue Shield plan, New York's United Medical Service, now has 2 million subscribers, pays doctor $1 million a month.

More and more small state societies likely to put on joint scientific meetings. Vermont and New Hampshire say their recent joint convention attracted more distinguished speakers, promoted more new friendships, brought more mutual problems under discussion. Exhibitors like idea, too; say they can produce better show . . . "A Medal for Bowzer," new comic book being distributed by Pennsylvania state medical society, tells how animal experimentation helps medical research despite opposition of maudlin meddlers . . . Innovation: Nineteen laymen are now members of Colorado State Medical Society's public health committees; they represent press, radio, nursing, farmers, parent-teachers associations, and businessmen.

ELI LILLY AND COMPANY *announces*

[redacted]

and thereby marks another

improvement in diabetes management

Clinical evidence indicates that single daily injections of NPH Insulin provide an efficiently timed Insulin effect which closely parallels average requirements over a twenty-four-hour period. This new preparation of Insulin eliminates, in most instances, occasion for mixed injections of Insulin and Protamine Zinc Insulin. In severe and complicated cases, supplementary doses of Insulin may be utilized, if indicated.

Lilly

Detailed information and literature pertaining to NPH Iletin (Insulin, Lilly) are personally supplied by your Lilly medical service representative or may be obtained by writing to

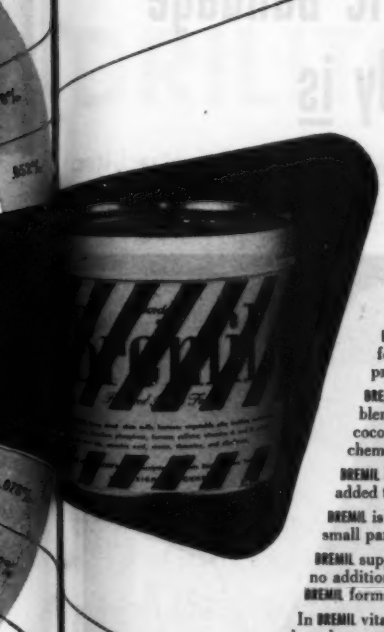
ELI LILLY AND COMPANY *Indianapolis 6, Indiana, U.S.A.*

a **new** *product*

flexible, palatable, easy to prepare

Bremil

conforming to the pattern of human milk . .



BREMIL—newest product of Borden research—introduces a significant advance in infant nutrition.

BREMIL is a completely modified milk in which nutritiona essential elements of cow's milk have been adjusted in order to supply the nutritional requirements of infants deprived of human milk.

In **BREMIL** the calcium-phosphorus ratio is adjusted to a minimum of 1½ parts calcium to 1 part phosphorus. Gardner, Butler, et al., state: "Relative to human milk, cow's milk has a low Ca:P ratio..."[1] Nesbit states: "Tetany of the newborn is now recognized as a definite entity... and often accompanied by an increased phosphorus and lowered blood calcium."[2]

BREMIL is fortified with ascorbic acid (vitamin C) not only for its antiscorbutic properties but also for its value in preventing megaloblastic anemia.[3]

BREMIL has the fatty acid pattern of human milk . . a scientific blending of three carefully selected vegetable oils (palm, coconut, peanut) which compares with human milk fat in physical, chemical and metabolic characteristics.

BREMIL has the amino acid pattern of human milk...with methionine added thereby "improving the biologic value of milk proteins."[4]

BREMIL is easily digested as it forms a soft flocculent curd of small particle size comparable to human milk.

BREMIL supplies the same carbohydrate (lactose) as breast milk... no additional carbohydrate is needed in the preparation of **BREMIL** formulas.

In **BREMIL** vitamins A and D, thiamine, riboflavin, niacin, and ascorbic acid have been *standardized at or above* the recommended daily allowances for infants as established by the National Research Council (revised 1948).

BREMIL is available in drugstores in 1 lb. cans.

Complete information and a trial supply may be obtained upon request.

1. Gardner, L. I.; MacLachlan, E. A.; Pick, W.; Terry, M. E., and Butler, A. M.: *Pediatrics* 5:228, 1950.
2. Nesbit, H. T.: *Texas State J. M.* 38:531, 1943.
3. May, C. D., et al.: *Bull. Univ. Minnesota Hospitals* 21:208, 1950.
4. Block, R. J.: *J. Am. Dietetic Assn.* 25:937, 1949.

powdered infant food

Prescription Products Division

The **BORDEN** *Company*

350 Madison Avenue, New York 17, N. Y.

NEWS ABOUT A BAUER & BLACK PRODUCT

Here is an elastic bandage that really is

TENSOR is the elastic bandage that's woven with live rubber thread—provides pressure without binding.

You can't expect the conventional elastic bandage, whose only "give" is that of the cotton threads, to provide the elasticity of *Tensor*, made with *live rubber* threads.

Nor can you expect the same results.

Tensor provides uniform pressure—controlled pressure—without binding. Wide range of pressure. Ease of adjustment. Ability to stay firmly in place. Elimination of frequent adjustments. Greater mobility and comfort for the patient. Maintains elasticity after repeated launderings.

Aren't these all worth-while reasons for your preference for *Tensor*?

TENSOR*

THE ELASTIC BANDAGE THAT'S WOVEN WITH LIVE RUBBER THREAD

BAUER & BLACK

*Reg. U. S. Pat. Off.

Other famous Bauer & Black Elastic Supports: BRACER Supporter Belt, Elastic Stockings, Abdominal Belts, Suspensories, Anklets, Knee Caps, Athletic Supporters*

BAUER & BLACK, DIVISION OF THE KENDALL COMPANY, 2500 S. DEARBORN ST., CHICAGO 16, ILL.

the least toxic sulfonamide studied*

Yes, SULFACETAMIDE . . . the least toxic sulfonamide reported in Lehr's clinical studies . . . is now combined with sulfadiazine and sulfamerazine as Pansulfa, with these therapeutic advantages:

1 The established antibacterial power of three sulfas.

2 Less danger of crystalluria or renal damage.

3 Uniform dosage—the thixotropic gel of the suspension assures even dispersion. Also available in palatable tablets.

Pleasant tasting

PANSULFA

SULFACETAMIDE
SULFADIAZINE
SULFAMERAZINE

Each teaspoonful or tablet contains 0.5 Gm. (7½ grs.) of the rapidly soluble sulfonamides 1:1:1

Also

PANSULFA WITH PENICILLIN

(Each tablet contains 100,000 units of Crystalline Penicillin Potassium G in addition to the above formula)

Merrell
1828
CINCINNATI • U.S.A.

*see Lehr, Di Federation Proc. 8:315 (1949)

"PANSULFA" trade-mark

Speaking Frankly

Loophole

A lot of state and county health, welfare, and mental hygiene departments are busy these days thumbing through their Civil Service regulations. Why? To find loopholes whereby officers and employees who volunteer for military service can be discharged from their civilian jobs.

Most civil service agencies, for example, provide for "presumptive resignations" after an absence of one year. Thus, after a doctor is in service for eleven months, his appointing officer writes him to return to his job at the end of a year. The physician obviously cannot. But his failure can be regarded as a presumptive resignation. Or he can be bounced for failing to obey an order.

Cute?

M.D., New York

Fees

A letter in your November issue said that in upstate New York a patient was charged $250 for a delivery and $250 for hospital care. This is hard to believe if it was a normal case. In upstate New York there are many excellent obstetricians whose average fee for an ordinary case is $150. Some charge a bit more, some less. The hospital bill for a semi-private room is about $100. This includes full care and delivery room. Blue Cross cuts about $40 from the hospital bill.

I believe that in Buffalo, Rochester, Syracuse, Utica, and Albany a patient can get good, *complete* maternity care for about $250—or maybe even less.

N. N. Cohen, M.D., President
Central New York Association of
Gynecologists and Obstetricians
Syracuse, N.Y.

I agree with "M.D., New York," that costs of $250 for obstetrical care plus $250 for hospitalization are way out of line for a family earning $50 to $60 a week.

But there must be a catch somewhere!

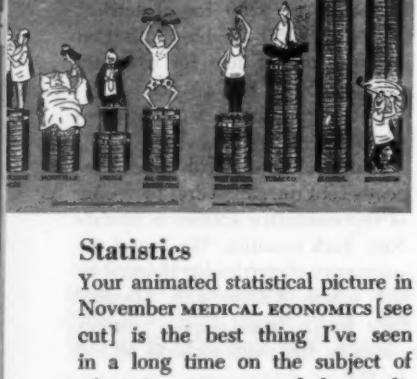
Our county medical society recently sent questionnaires to a score of representative doctors in upstate New York counties. We found the customary obstetrics fee charged by G.P.'s was $50 to $75. Hospital bills for a five-day stay usually range in the neighborhood of $60 to $80.

So I must presume that the $500 quoted by "M.D., New York" includes the services of an obstetri-

cal specialist and a private room. Specialists are entitled to higher fees because of their special knowledge and skill. But where the budget is so limited, why can't the family find a G.P. who is willing and able to handle "normal and spontaneous" deliveries at a reasonable fee? And where money is that scarce, wouldn't semi-private or ward accommodations do?

There are two sides to every story. Nobody would feel sorry for a $50-a-week man who complained that the cost of his Cadillac was too high. Why shouldn't the patient also select medical services according to the range of his pocketbook?

M.D., New York



Statistics

Your animated statistical picture in November MEDICAL ECONOMICS [see cut] is the best thing I've seen in a long time on the subject of what Americans spend for medical care compared with other expenditures.

May I suggest that you enlarge the picture and make it available to every M.D. in America for framing? Every waiting room should display one.

Lloyd K. Rosenvold, M.D.
Redlands, Calif.

I have seen nothing published so far on the comparative expenditures of the American public that is as revealing as your pictorial graph . . . I personally would like to have a number of these to distribute to my friends and patients.

J. A. Whieldon, M.D.
Worthington, Ohio

. . . best execution of these pertinent facts that I have ever seen. It tells the story in a fashion that everyone can understand. Every doctor's office and every hospital should have this chart on display.

R. F. Whitaker, Superintendent
Emory University Hospital
Emory University, Ga.

If enough requests are received to warrant a special printing of this chart, copies will be made available at cost.

Military

Will someone be kind enough to explain why we have to pay taxes to keep the medical reserve going? My husband saw fifty-two months of active duty in World War II. On leaving the Army he was given a choice of staying in the reserve or resigning. He chose to resign.

Now along comes the doctor-

draft law to protect those reservists who have been drawing money and getting credit toward a pension in return for merely fooling around a couple of hours every month.

Why bother having a reserve? It would be different if medical officers had been forced into the reserve. But, after all, they were given a choice. Maybe it's just fashionable these days to take as much as you can from the Government and never give anything in return. I fail to see any justice in the doctor-draft law.

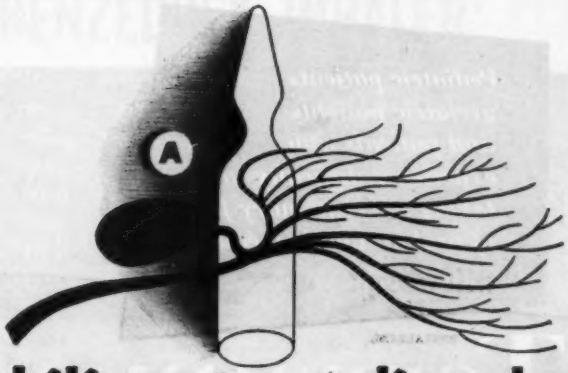
M.D.'s Wife, Illinois

I used to agree with the views expressed by M. Foster Whitten [October Speaking Frankly] but I no longer do. It doesn't seem fair to me that the same doctors who went to war last time should go again. But that's exactly what would happen without a doctor draft.

Neither is it fair to keep doctors in the inactive reserve without their consent. We volunteered for one war (with plenty of urging from the AMA and state societies) but shouldn't be expected to go every time. In fact, I think the best thing to do would be to discontinue the reserve entirely and draft doctors according to the time they previously put in.

C. P. Kauth, M.D.
Port Washington, Wis.

I think someone should delve into the medical-reserve-officer farce. Some of these men have had from three to five years of active duty;



in biliary tract disorders

Hydrocholeresis with *Decholin* and *Decholin Sodium* produces a gentle lavage of the biliary tree. Copious, fluid bile flushes away mucus, pus and thickened bile and re-establishes normal drainage.

for best results

Hydrocholeretic therapy should be extended through the optimal treatment period. An *average* dose of *Decholin* is 1 or 2 tablets three times daily for four to six weeks. Prescription of 100 tablets is recommended for maximum efficacy and economy. The course may be repeated after an interval of one or two weeks if desired. For more rapid and intensive hydrocholeresis, therapy may be initiated with *Decholin Sodium*.

DECHOLIN

Decholin tablets (brand of dehydrocholic acid) of 3¼ gr. (0.25 Gm.), in bottles of 100, 500, 1,000 and 5,000.

Decholin Sodium (brand of sodium dehydrocholate) is supplied in a 20% solution for intravenous administration. 3 cc., 5 cc. and 10 cc. ampuls — boxes of 3, 20 and 100.

Decholin and *Decholin Sodium*, trademarks reg.

AMES COMPANY, INC · ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

Pediatric patients
geriatric patients
and patients who
experience difficulty in
taking the customary forms
of oral antibiotic medication

Terramycin

ELIXIR

the only broad-spectrum antibiotic available as an elixir.

One teaspoonful (5 cc.) provides

250 mg. TERRAMYCIN HYDROCHLORIDE

CHERRY-COLOR APPEAL
CHERRY-MINT FLAVOR

High dosage concentration assures therapeutic efficacy without requiring unwieldy dosage schedules. Provides convenience and flexibility in dosage.

Available at prescription pharmacies in bottles containing 1 fl. oz.

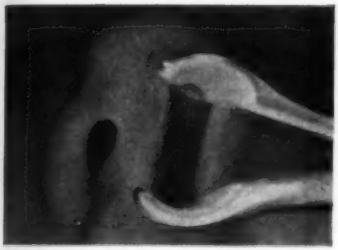
Antibiotic Division **Pfizer** CHAS. PFIZER & CO., INC.
Brooklyn 6, N.Y.

more rapid, complete and prolonged shrinkage with BENZEDREX INHALER:

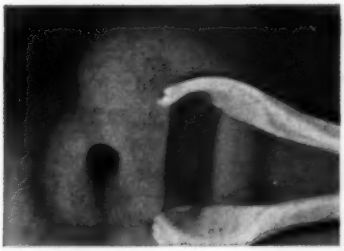
After 5 minutes.
Benzedrex Inhaler has produced virtually complete shrinkage.

After 1 hour.
Benzedrex Inhaler still provides almost complete shrinkage.

for comparison—shrinkage with ephedrine:



After 5 minutes.
Shrinkage does not compare with that of Benzedrex Inhaler.



After 1 hour.
The ephedrine nostril is almost completely occluded.

Before treatment the patient's inferior turbinate almost completely obstructed the airway in both cases. The only variable was the vasoconstrictor used.

These photographs reveal why physicians tell us that Benzedrex Inhaler is the best inhaler they and their patients have ever used.

You can recommend Benzedrex Inhaler for nasal congestion between office treatments with assurance. It will not cause excitation or wakefulness.

Smith, Kline & French Laboratories, Philadelphia

BENZEDREX INHALER

'Benzedrex' T.M. Reg. U.S. Pat. Off.

New *life* for the living

When the patient resigns herself to mere existence during the middle period of life, depression can so easily get the upper hand. The seemingly endless, daily routine of living is approached with apathy, inertia and lack of interest; and the patient's own outlook on life drags her down the path to eventual break-up—physical as well as mental.

For such a patient 'Dexedrine' Sulfate is of unequalled value. Its uniquely "smooth" antidepressant effect restores mental alertness and optimism, induces a feeling of energy and well-being. By helping to revive the patient's interest in daily affairs, 'Dexedrine' has the happy effect of bringing back *life* for the living.
Smith, Kline & French Laboratories, Philadelphia

Dexedrine* Sulfate

tablets • elixir **the antidepressant of choice**

*T.M. Reg. U.S. Pat. Off.

and now, because they made a patriotic gesture in signing up when they were released from service, they face recall before the multitudes who never served at all.

The story at the separation center went like this: You may as well sign up since your time builds up and you can resign at any time. There's nothing compulsory about it. If war comes, all doctors will have to go in anyway, and you'll be that much better off.

What was never explained was that you can resign only after the war has been declared ended. This, of course, has never happened.

Many of us realized we had been hoodwinked and tried to resign. But nothing doing. After several years we were put in the inactive reserve and thought we were out. Fooled again. It is the inactive reserves who are being called into service. The joker is that those in this group never received a cent of remuneration and wanted only one thing: OUT.

M.D., Michigan

Movies

Something is missing from the extensive library of medical motion pictures presently available to physicians. It's well known that such films enable us to learn faster and remember longer. When televised, they reach a great many practitioners. But so far the films we have deal mainly with the basic subjects of anatomy, surgical pathology, clinical diagnosis, and general and plastic surgery. [*Turn page*]

What we should also have are films showing laboratory procedures. These are needed (1) as aids in clinical diagnosis and treatment, and (2) to round out the training of both medical student and practitioner.

While it isn't necessary for everyone to master the various laboratory procedures, motion pictures would help us appreciate their interpretation and significance.

As for televising such films, they can be shown on regular channels without fear of offending the lay audience (as might be the case with other medical or surgical films). In fact, the public would probably appreciate knowing about the service rendered by their doctors in performing these tests.

Jacob Sarnoff, M.D.
Brooklyn, N.Y.

Prexies

True, Kentucky is the top producer of AMA presidents. Seven native sons have made the grade. But did you also know that the University of Louisville leads all other schools in the same respect? Dr. Elmer Henderson is the twelfth prexy to graduate from U. of L.'s venerable medical school.

William G. Caldwell, M.D.
Hollywood, Calif.

Druggists

I want to back "M.D., Illinois" for his timely warning about druggists treating patients. The druggist who treats a patient is seriously endangering the public health. Examples

Poly-Vi-Sol Tri-Vi-Sol Ce-Vi-Sol

for their varying vitamin needs..

	VITAMIN A	VITAMIN D	ASCORBIC ACID	THIAMINE	RIBOFLAVIN	NIACINAMIDE
POLY-VI-SOL each 0.6 cc. supplies:	5000 units	1000 units	50 mg.	1 mg.	0.8 mg.	5 mg.
TRI-VI-SOL each 0.6 cc. supplies:	5000 units	1000 units	50 mg.			
CE-VI-SOL each 0.5 cc. supplies:			50 mg.			

3 water-soluble liquid vitamin preparations...

pleasant tasting, convenient, economical. Available in 15 and 50 cc. bottles with calibrated droppers.

MEAD'S

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U. S. A.

are plentiful: The cough that may be a symptom of tuberculosis, the "gas condition" that may mask a coronary attack. The responsible authorities should see to it that the druggists mind their own business, which is to fill prescriptions but not to practice medicine.

M.D., New York

"M.D., Illinois:" You lose sight of many things when you take a slap at your allied profession, pharmacy. There are thousands upon thousands of pharmacists who definitely refuse to counter-prescribe. I am one of them, and I've worked with dozens of others. You should keep in mind that there are, and probably always will be, "stinkers" in *both* medicine and pharmacy. Neither you nor I should judge the whole by the few!

Your profession and ours are working more closely together now than at any time in the past. That's one reason why we see to it that a copy of your AMA literature against socialized medicine is wrapped with every item that leaves our store.

And so, "M.D., Illinois," when I read a thoughtless remark such as yours in a national publication, I am disturbed. I feel as though I've discovered another "stinker" in the medical profession. Yet, I'm glad that you are so far away from the nice bunch of physicians and pharmacists whom I know and with whom I am in daily contact.

Darwin L. Sayers, Pharm. D.
Reynoldsville, Pa.

When the diagnosis is Pyelitis

First: consider

to establish and maintain urinary antisepsis...

To establish and maintain urinary antisepsis, MANDELAMINE® is many times preferred because it is quickly effective against the organisms most commonly encountered in urinary-tract infections. Its exceptional freedom from untoward reactions and its wide range of antibacterial activity commend it for use as soon as the diagnosis has been made.

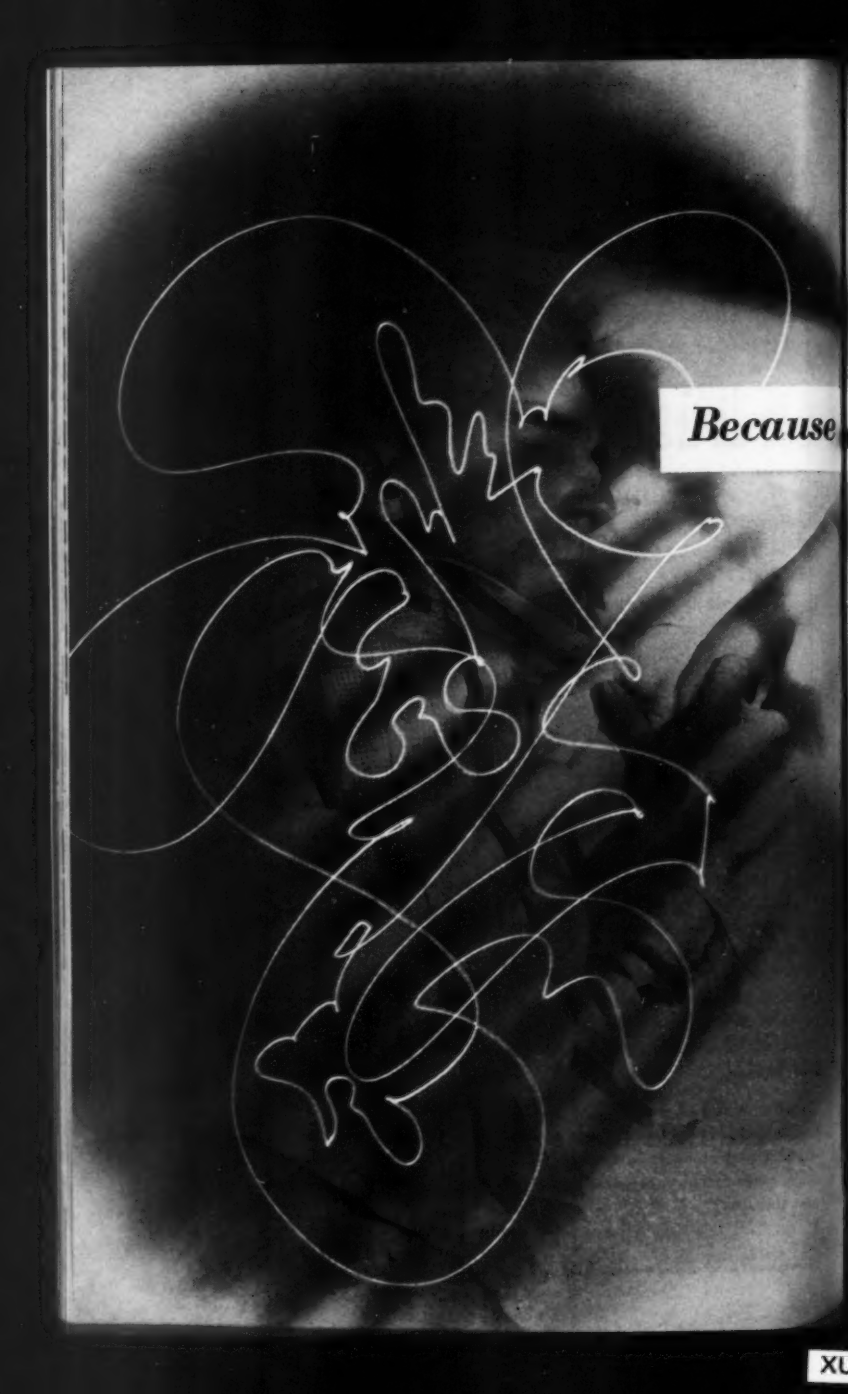
Urinary antisepsis is often achieved in uncomplicated pyelitis in as few as three days. Speedy recovery is thus secured in many cases without necessitating higher-cost therapy.

Renal insufficiency is the only major contraindication to MANDELAMINE therapy.

MANDELAMINE is available in bottles of 120, 500, and 1,000 enteric-coated tablets, through all prescription pharmacies. Comprehensive literature and samples for clinical trial will be furnished to physicians on request.

NEPERA CHEMICAL CO., INC.
Pharmaceutical Manufacturers
NEPERA PARK, YONKERS 2, N. Y.

®MANDELAMINE is the registered trademark of Nepera Chemical Co., Inc., for its brand of methenamine mandelate.


Because

tients can't

"SLEEP OFF" *hypertension...*

prolonged vasodilation should accompany sleep as well as the day's activities. (One more reason why NITRANITOL is the most universally prescribed drug in the management of hypertension.)

NITRANITOL®

FOR GRADUAL, PROLONGED, SAFE VASODILATION

Merrell
1828
CINCINNATI • U.S.A.

When vasodilation alone is indicated. *Nitranitol.* (½ gr. mannitol hexanitrate.)

When sedation is desired. *Nitranitol with Phenobarbital.* (½ gr. Phenobarbital combined with ½ gr. mannitol hexanitrate.)

For extra protection against hazards of capillary fragility. *Nitranitol with Phenobarbital and Rutin.* (Combines Rutin 20 mg. with above formula.)

When the threat of cardiac failure exists. *Nitranitol with Phenobarbital and Theophylline.* (½ gr. mannitol hexanitrate combined with ½ gr. Phenobarbital and 1½ grs. Theophylline.)

Meets every requirement for all diathermy technics...

the GE INDUCTOTHERM

FROM diathermy treatment of the ear to that of a pelvis or chest — the GE Inductotherm meets the most exacting clinical approval. Brings you the practical, the efficient, the easy means for obtaining the desired quality and intensity of energy indicated for proper treatment.

As for output, the Inductotherm has the capacity to elevate the temperature in any region of the body to the limit of the patient's tolerance. The perfect answer to fulfill your needs over the *entire range* of modern diathermy technics.

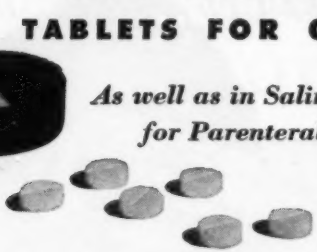
Ask your GE representative for more details about the Inductotherm — or write General Electric X-Ray Corporation, Dept. C-1, Milwaukee 14, Wisconsin.

GENERAL ELECTRIC
X-RAY CORPORATION

Cortone®

NOW AVAILABLE IN TABLETS FOR ORAL USE

As well as in Saline Suspension for Parenteral Therapy



CORTONE* (Cortisone) now is available in tablets for oral administration, as well as in saline suspension for parenteral use, through your usual sources of medicinal supplies.

Clinical studies have demonstrated that the therapeutic activity of Cortone administered orally is comparable to that of the parenteral form. Dosage requirements are approximately the same, and the two routes of administration may be used interchangeably or additively at any time during treatment.

CORTONE Tablets, 25 mg. each, are supplied in bottles of 40, totaling 1 gram, the equivalent in Cortone content to 2 vials of the saline suspension. The cost per gram to the physician is approximately the same as that of the saline suspension for parenteral use.

Literature on Request

Among the conditions in which Cortone has produced striking clinical improvement are:

RHEUMATOID ARTHRITIS and Related Rheumatic Diseases

ACUTE RHEUMATIC FEVER

ALLERGIC DISORDERS, including Bronchial Asthma

INFLAMMATORY EYE DISEASES

SKIN DISORDERS, notably Angioneurotic Edema, Atopic Dermatitis, Psoriasis, Exfoliative Dermatitis, including cases secondary to drug reactions, and Pemphigus

LUPUS ERYTHEMATOSUS (Early)

ADDISON'S DISEASE

Cortone®

ACETATE

(CORTISONE Acetate Merck)

(11-Dehydro-17-hydroxycorticosterone-21-acetate)

**CORTONE is the registered trade-mark of Merck & Co., Inc. for its brand of cortisone.*

MERCK & CO., INC.

Manufacturing Chemists

RAHWAY, NEW JERSEY

Sidelights

Tax Tip

Uncle Sam's income tax agents have been taking a narrow-eyed look lately at physicians' entertainment deductions. "Sure," some of them say, "it's all right to deduct social expenses connected with the advancement of your professional career. But we want proof that they *are* connected."

That means not only proof of the outlay—canceled checks, receipted club bills, and the like. It also means proof of the benefits derived—referrals, new patients, and such.

This crack-down isn't country-wide; much depends on how the individual revenue agent interprets the rules. If your entertainment deductions bear a reasonable relation to your net income, chances are still good that they'll be approved. But if your deductions for dinners, theater parties, and golf foursomes bulk large, better expect a tussle.

One high official of the Bureau of Internal Revenue sums up its policy thus: "Any businessman—doctor or traveling salesman—must be ready to prove that his entertainment deductions have a direct relationship to the income he earns. When physicians are disallowed these deductions, it's nearly always because they cannot prove that their fees resulted, directly or indirectly, from such entertainment."

Twilight Area

What, exactly, should be done about the people who can't afford voluntary health insurance?

The question is raised by the AMA's twelve-point program, which calls for "aid through the states to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans." Yet for nearly two years, the question has lain on the table. More pressing matters have kept it from discussion and debate.

Meanwhile, the submerged question has spawned a lot of other questions. For example: Are we for or against Federal aid to the voluntary plans? Are we for or against state aid? What specific mechanism do we suggest for using tax funds? What standards can we suggest for determining need? What legislative form should this proposal take? How do the Hill, Taft, and Flanders health plans fit this formula?

These posers are as tough as any that now confront us. Which makes it high time we dragged them out into the open. Until we do, we

won't convince anyone that our profession has a full and feasible program of its own.

AMA Balance Sheet

In preparing the article titled "How to Read a Balance Sheet," which you'll find beginning on page 142, the author had occasion to look up some AMA balance sheets of recent years. He reports an interesting and laudable metamorphosis in these documents.

Back in 1947, for example, the association listed its liabilities ahead of its assets, an almost unheard-of state of affairs in accountancy. By long-standing custom among balance-sheet designers, the asset column goes either above or to the left of the liability column.

By 1948 the AMA treasurer had turned his balance sheet right side up, but in so doing had jumbled its contents a bit. Current assets, which properly should top the asset column, were down near the bottom; fixed property, which should go near the bottom, was at the top. A minor matter to you and us, perhaps, but a pretty kettle of fish to a CPA.

In the 1949 year-end statement, we're happy to say, current assets were up where they belonged, plant and equipment down where *they* belonged. In fact, it wasn't a bad-looking balance sheet, from either a financial or analytic-esthetic point of view.

True, a stickler for accounting niceties could cavil at the listing of

Doctor... listen to this conversation about you!

PATIENT... *There was so little discomfort in having that mole removed.*

NURSE... *The Doctor's new technic with the HYFRECATOR is wonderful!*

PATIENT... *You can tell the Doctor I'm going to have my sister come in. She worries about a mole on her abdomen.*

NURSE... *It's a good idea to have him look at it to make sure... and he'll know if it should be eradicated with the HYFRECATOR.*

Over 70,000
HYFRECATORS
in daily use

to eradicate moles, warts, unwanted hair and other superficial growths. Many doctors use the HYFRECATOR...High Frequency Eradicator...for fulguration and bi-active coagulation as well as desiccation. They find that the HYFRECATOR'S double spark gap power, accurately controlled and smoothly graded current... exactly meets their individual office electrosurgical demands.

The BIRTCHER Corporation
Los Angeles 32, California

And Doctor... Please Note

The increasingly widespread public knowledge of the danger of moles as fore-runners of skin cancer have made your patients more receptive to your suggestion that all suspect lesions be eradicated. New reprints on Precancerous Lesions are available. Write your name and address – mail for your copies.

ERADICATE THAT SUSPECT PRECANCEROUS LESION

To: The BIRTCHER Corp., Dept. M 1-51
5087 Huntington Dr., Los Angeles 32, Calif.

Please send me free reprints on Precancerous Lesions and Literature on the Hyfrecator.

Name.....

Street.....

City.....State.....

certain security investments at cost when, marketwise, they were worth less than cost. And he might wish for better segregation of assets the association considers current.

But these are minor faults and may well be remedied when the 1950 balance sheet appears. Alas, that won't be until June (no big corporation could get away with such slow reporting to stockholders). Moreover, if past custom prevails, it will be published only in the handbook issued to delegates.

Why not sooner—and in the Journal AMA—for all to have a look-see?

Keynote in Congress

Perhaps you've wondered about the temper of the new Congress on health matters. The majority outlook is summed up accurately, we believe, by Senator Thomas Hennings (D., Mo.): "There is no magic in names. Medical care directed by the Government is socialized medicine. The cost is high and the quality poor."

One of the Senator's constituents, by the way, is a man named Harry Truman.

Rx for Reporters

Are doctors people? Some newspaper men seem to doubt it. Because of medicine's reserve in dealing with the press, relations between the two tend to be a mite frosty.

One of the best defrosters we know about is the press-radio dinner. This is a strictly social affair

acidolate

easily cleanses dirty traumatic wounds

Both fat-soluble and water-soluble dirt are readily removed from dirty wounds simply by inundating the area with Acidolate and rinsing with warm water. Vigorous application, with painful aggravation of injured tissues, which so often attends the use of other cleansing agents is avoided.

High value as a wetting agent, particularly its low surface tension, causes Acidolate to penetrate deep recesses of the wound. Oil, grease and other fatty materials are quickly emulsified and are flushed from the wound, together with water soluble dirt, when the area is rinsed. Epithelial and other tissue debris are effectively loosened and easily washed from the wound.

The pH of Acidolate closely approximates that of healthy skin — the integrity of the normal "acid mantle" is maintained.

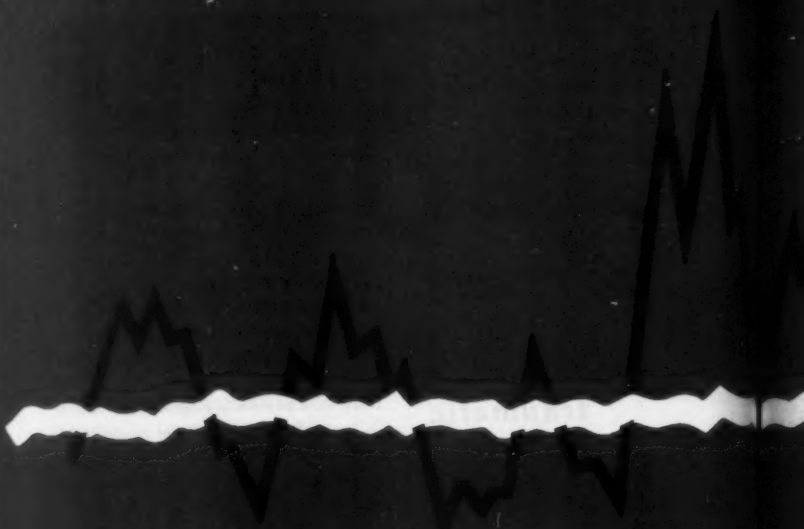
Supplied: Acidolate, a non-lathering, non-irritating, hypoallergenic liquid detergent, in bottles of 8 fluid ounces and one gallon.

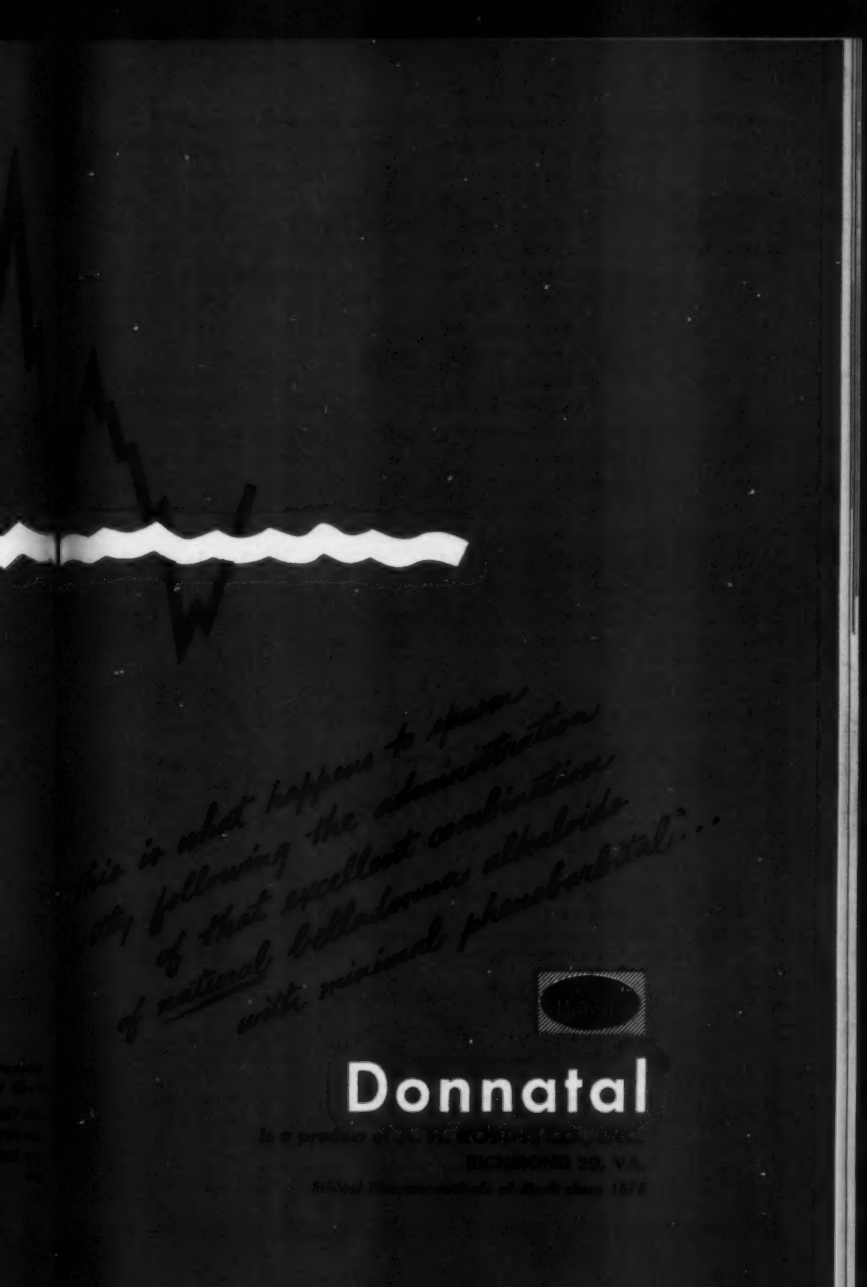
RARE-GALEN DIVISION OF

WHITE LABORATORIES, INC.

PHARMACEUTICAL MANUFACTURERS

NEWARK 7, NEW JERSEY





sponsored by the local medical society. Its sole aim is to acquaint leading newsmen in the area with leading physicians. The guest list includes newspaper reporters, radio newscasters, magazine writers, wire service men, and all officers (plus key committee chairmen) of the medical society. The evening is devoted to cocktails, a good dinner, and congeniality—minus speeches.

Why is the idea important? Because it helps put medical press relations on a man-to-man basis. Witness this example from Colorado:

Shortly after the third annual press-radio dinner in Denver, a local school teacher fell or jumped from a second-story window of the school building. Reporters wanted to know: Was it attempted suicide? Should they say so in print?

While the woman fought for life, one reporter called her physician. In the old days, such a call might have elicited only a curt and careful, "No comment." But these two men had met at the press-radio dinner. They felt they knew each other. So the physician freely explained things thus:

"That woman is going to recover. But since she's emotionally upset, any public reference to a suicide attempt would retard her recovery. I'd advise against mentioning it—but, of course, the matter is in your hands."

That was the last heard of the suicide angle—and, among local newsmen, of the notion that doctors aren't people.

the patient

FAILED

to respond

to the usual multi-vitamin therapy

Only recently has medical science discovered why multi-vitamins frequently fail to correct symptoms of multi-vitamin deficiency. By tracing many nutrients through the body with the aid of radioisotopes, it has been proved that WITHOUT MINERALS AND TRACE ELEMENTS, VITAMINS ARE USELESS.

In addition, minerals, trace elements and vitamins are now known to play both a prophylactic and therapeutic role in many specific conditions, heretofore unidentified with nutritional therapy

Diabetes, cardiovascular diseases, undulant fever, senile dysfunctions and the many conditions requiring diet, have been found to respond to mineral, trace element and vitamin supplementation.

VITERRA, by providing balanced proportions of 12 MINERALS and TRACE ELEMENTS and 9 VITAMINS, hastens convalescence and helps maintain optimal well-being.

12 MINERALS
AND
9 VITAMINS
all in one capsule

Cobalt	0.1 mg.
Copper	1 mg.
Boron	0.2 mg.
Iron	10 mg.
Iodine	0.15 mg.
Calcium	213 mg.
Manganese	1 mg.
Magnesium	6 mg.
Molybdenum	0.2 mg.
Phosphorus	165 mg.
Potassium	5 mg.
Zinc	1.2 mg.
Vitamin A	5,000 USP Units
Vitamin D	500 USP Units
Thiamine HCl	3 mg.
Riboflavin	3 mg.
Pyridoxine HCl	0.5 mg.
Niacinamide	25 mg.
Ascorbic Acid	90 mg.
Pantothenate	5 mg.
Tocopherols, Type IV	3 mg.

Viterra

J. B. ROERIG AND COMPANY, Chicago 11, Illinois

for Coughs...

in acute and chronic bronchitis, paroxysms of bronchial asthma, dry catarrhal coughs—not due to organic disease . . . whooping cough . . . smoker's cough . . .

PERTUSSIN Stimulates the Flow of the Respiratory Tract Fluid

The effect of PERTUSSIN'S active ingredient, Extract of Thyme (made by the unique Taeschner Process), is to:

- Relieve dryness by stimulating tracheobronchial glands
- Facilitate expulsion of viscid or infectious mucus
- Improve ciliary action
- Exert a soothing and mild sedative effect on irritated mucous membranes

PERTUSSIN is entirely free from harmful ingredients of any kind. It is well tolerated—without undesirable side action. It may be given to children and adults in large doses and is pleasant to take.

Dose—adults: a tablespoonful; children: a teaspoonful; under two years: half a teaspoonful—every hour during the day, or until the cough subsides. Thereafter, every two or three hours, as needed. Samples on request.

SEECK & KADE, INC. • NEW YORK 13, NEW YORK

Mme. Golightly

knows vitamins slightly

For the anoretic mam'zell whose diet hardly includes *food*—let alone vitamin balance . . . for the smokers and topers, the hurriers and worriers food-skipping their way to a subclinical vitamin deficiency, have you tried DAYAMIN? One or two of these little vanilla-flavored capsules a day ideally supplement new dietary regime. (See formula.) In bottles of 30, 100 and 250. For those who dislike capsules, try DAYAMIN Liquid . . . with the citrus-like flavor and odor. Supplied in bottles of 90 cc., 8 fluidounces and 1 pint.

Abbott

Each DAYAMIN capsule contains:

Vitamin A	10,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Hydrochloride	5 mg.
Riboflavin	5 mg.
Nicotinamide	25 mg.
Pyridoxine Hydrochloride	1.5 mg.
Pantothenic Acid (as calcium pantothenate)	5 mg.
Ascorbic Acid	100 mg.

Prescribe

DAYAMIN®

(ABBOTT'S MULTIPLE VITAMINS)

Editorial

Citizens First

• Home-town folks had never seen anything like it. Doctors came out of their consultation rooms as never before to take part in civic affairs. Service clubs, chambers of commerce, and other community groups enjoyed an influx of M.D. members. The phenomenon began early last year and continued right up to November 7.

Was this a one-shot performance?

Some people think so. Here, for example, are the bleak reactions of two civic leaders who were sounded out by Dr. Raymond B. Allen, president of the University of Washington:

"The doctors' sole interest was apparently in combating socialized medicine. At our meetings, they spoke against it on every occasion. But they made no suggestions for the improvement of medical care in this community."—*A chamber of commerce head.*

"The pattern of community leadership by the medical profession has been pretty spotty indeed. Unless such leadership becomes the rule rather than the exception, medical men will have to accept an excursion into Federal medicine which, however ill-advised, has at least been presented with vigor and directness . . ."—*A public relations counselor.*

"We must remember," Dr. Allen adds, "that we are citizens first and doctors second. Unless we exercise the [home-town] leadership of which we are capable, we shall lose what we stand for as professional people and as Americans."

These warnings can't be shrugged off. Note that they apply not just during election campaigns, but every year—all year round.

Most health issues will, after all, be settled not by the politicians but by the people. What's more, such issues may well be settled by *local* people. Does your town need more hospital beds? Are your neighbors dissatisfied with the brands of health insurance available? What about indigent care and public health services? Washington planners can't possibly compete with home-town leaders in devising solutions that fit *your* community.

But home-town leaders need much more guidance from doctors. What better place to exert it than in existing community groups?

This past year, most of us have had at least a taste of civic activity. It's time we made it a steady diet.

—H. SHERIDAN BAKETEL, M.D.

Your Practice Five Years Hence

What can you expect by 1956? Herewith the stuff of which informed guesses are made

• Assuming no national compulsory health insurance and no all-out war by 1956 (which, even as assumptions go, is taking a lot for granted), what's ahead for the average U.S. physician?

Plenty.

While no radical changes in day-to-day practice loom ahead, the gradual, more subtle changes are all-important and bear close watching.

The most significant trend is that from individual to collective action —both by doctors and by the public.

We medical men have long pictured ourselves as of the genus *Individualist*, species *Rugged*. We're good at giving orders, bad at taking them (who, if not the doctor, makes the world's worst patient?). We do as our consciences dictate and resent being told to account to anyone.

The second half-century, it seems likely, will be an age of growing teamwork. The signs are visible already:

¶ In the strengthening of our medical societies and the tightening of their disciplinary machinery;

¶ In the steady spread of voluntary health insurance;

¶ In the expanding influence of hospital staffs;

¶ In the growth of group practice;

¶ In necessarily closer working relations with people of other occupations: technicians, dietitians, social workers, therapists, dentists, nurses, businesmen, the public at large.

The people's shift from individual to collective action shows itself mostly in the trend toward Big Government. Over medicine, as over countless other beachheads, the waves of government break higher each day. Few doctors want this. Yet few are doing enough to roll back the tide.

There is increasing pressure on city and county governments for expansion of dispensary and clinic services. State governments are building more and more TB hospitals, diagnostic centers, psychiatric institutions, and clinics for the medically indigent.

At the Federal Government level, the prime example is the Veterans Administration. By 1956, the V.A. expects to be operating a minimum of 135,000 hospital beds.

The President's Committee on Veterans' Medical Services—a nongovernmental group—sees a number of dangers in this expansion; but it has apparently given up hope of stopping it. At least, it confines its counsel to ways of better staffing V.A. beds.

Congress is no less skittish. To try to halt V.A. hospital expansion, it has decided, would be political dynamite. Yet V.A. expansion, if fully realized, will give 9 per cent of *all* U.S. hospital beds to just this one Government agency.

And the V.A. isn't alone in its glory. The armed services in the next five years will also boom. Which means new hundreds of thousands of soldiers, sailors, airmen (and, in many cases, their civilian dependents) entitled to Federal medical services.

It takes no soothsayer, then, to predict the exercise of growing authority by government, at all levels, in the provision of medical care.

Incomes in '56

Since no one knows whether 1956 will see inflation, depression, prosperity, or a holocaust, and since medical business conditions reflect those of general business, income predictions are among the most speculative. Study of the factors that will tend to raise or limit medical incomes is the best avenue to an intelligent guess of what's ahead.

A strong brake on any rise in the doctor's net income is the rise in his operating costs; for every year, equipment and supplies become more diverse, more complicated—and more expensive. Other brakes are the wider use of fee schedules

and the growth of self-disciplinary machinery in our medical societies (*e.g.*, grievance and fee-adjustment committees).

Among the things that will tend to boost medical incomes is technological progress. This gives the doctor more to offer, thus inviting people to see him more often. At the same time, it enables him to work faster and so absorb the heavier patient load.

To the extent that there may be some shortage (or maldistribution) of doctors, incomes will be further stimulated. Other positive factors are an increased collection rate (as more medical bills are paid by private and government agencies) and the fact that the demand for medical care (unlike the demand for, say, TV sets) can't drop very much.

Probable outcome for physicians by 1956: substantially higher dollar incomes, only moderately higher real incomes.

Work Load Up

Chances are, the charity work you do now is far less today than it was a decade ago. For one thing, more people now have health insurance. For another, more people have jobs.

In five years, the majority of middle-class patients probably will have medical insurance, just as the majority now have hospitalization insurance. The indigent, meanwhile, will be beneficiaries of some kind of tax-supported welfare plan. Taken together, these two factors should come close to wiping out your free list by 1956.

But the same factors will increase your work load. Patients with health insurance consult the doctor earlier, oftener. Ditto for patients whose medical costs are paid by government.

A logical way out will be to increase office efficiency. More and better trained office assistants will also ease the load.

Office Records

When the doctor-patient relation was a simple, two-way proposition, medical records had only to satisfy the practitioner. But by 1956, great numbers of medical bills will be paid by health insurance plans, by Federal Government agencies like the V.A., and by local and state welfare commissions.

Such a third party paying a medical bill can—and will—demand three things: (1) that the findings support the diagnosis, (2) that the records be made available—or abstracted—for reports, and (3) that some kind of standard nomenclature be used.

Physicians who scrawl their records on odd bits of paper are going to have a hard time meeting those demands. The solution will be to keep records in applie-pie order—sufficiently detailed, efficiently filed.

The renaissance of the G.P., already under way, will carry well beyond 1956. The burgeoning American Academy of General Practice, its popular new journal,

the growing number of G.P. sections in hospitals and medical societies—all testify to this.

If You're a G.P.

Since the G.P.'s fee is generally lower than the specialist's fee for the same service, the G.P. will be called upon often by insurance companies and other agencies footing the bills for patients. True, these agencies will sometimes insist on consultants. But in picking consultants they will rely on some easily-recognized yardstick of specialist status—like membership in a specialty society or a specialty board diploma. This tightening of specialist requirements will squeeze out many of the part-time and some of the self-trained specialists. Thus the ranks of the G.P.'s will be swelled further.

Hospital construction in small towns is certain to continue. This will broaden the family doctor's hospital opportunities.

The main fields in which the G.P. is not likely to gain eminence are the medical schools and the national and state medical societies. There the pattern of specialist control seems well established.

Medical schools recognize that every part of the human body can be assigned to some specialty, so they look to the expert in that specialty to do their teaching. Some schools have tried using G.P.'s to give courses in "practice." But these experiments have not been too well received. [*Continued on* 165]

Show Them What They're Paying For

● The canasta club talk shifted from what Mrs. Ackerman had been charged for a porterhouse steak to the cost of Patty Pendleton's latest physical checkup.

"I was in his office just two hours and I got a bill for $36," Patty complained. "And the only thing it said was 'For professional services.'"

"In *my* husband's business they break down a bill into separate items," said Sue Adams. "But I guess doctors are too high-hat for that."

"Well, the strategy's easy enough to see through," said Mrs. Ackerman. "If everything were in black and white, they couldn't hide behind [*Continued on* 203]

Doctors Winning Union Support

First cracks are seen in organized labor's united front on the health insurance issue

● In Topeka last fall, an unexpected visitor walked into the offices of the state medical society. He was the president of the Kansas Railroad Brotherhood—which, like nearly all labor unions in the U.S., had long fought the physicians on the issue of national health insurance.

But this time the labor chieftain was in a noncombatant mood. He asked leading questions about the Ewing plan—about its effects on union members. Finally he blurted out: "People seem to think that labor's rank and file is 100 per cent for socialized medicine. It isn't—not by a long shot. I'm convinced that we've had poor leadership on this issue."

With the doctors' help, he set about squaring the record. A speech was prepared; air time was purchased. Sixteen Kansas radio stations eventually carried his blast at compulsory health insurance—and his union picked up the bill.

No gap has been wider than that between organized medicine and organized labor. As the AMA's Clem Whitaker put it last month, "It has disturbed all of us that the major labor organizations, almost without exception, either have remained adamant in their espousal of socialized medicine or have stood aloof from the battle. Some of the bitterest attacks on the medical profession have emanated from labor leaders who have been infected by Oscar Ewing's poisonous propaganda.

"But let me give you this assurance: There *is* enlightened leadership in labor. There are many union men who are wholly out of sympathy with the ruthless campaign of hate which has been conducted against the medical profession. In local union leadership all over the nation there is strong support for American medicine—if it can be brought into the open."

Chances are, it can be. The signs are unmistakable that millions of working people are about ready to ditch the Ewing plan. For example:

The United Mine Workers is an independent union with 600,000 members. Three years ago, it officially endorsed compulsory health insurance. But after last spring's primary elections, the UMW Jour-

nal began to talk sympathetically about the "resentment of the voters to national medicine." Warned the editor: "On the medical question, labor had better begin to think . . ."

Most UMW locals took his advice; they supported anti-compulsion candidates during the fall political campaigns. In at least one case (that of Senator Francis Myers in Pennsylvania) the UMW was instrumental in getting a pro-compulsion candidate to switch his health views.

Another crack in the union facade appeared in Arkansas. Twelve local AFL unions—painters, barbers, postal workers, and such—bought advertising space to endorse the doctors' stand. In Indiana, a still greater number of AFL locals passed resolutions against compulsory health insurance.

Hammer blow at the Ewing plan is struck by William L. Hutcheson, boss of the AFL carpenters' union.

Bigger cracks were in the making. Thomas Murray, president of the New York State Federation of Labor, broke the news that his half-million members had soured on the Ewing plan. Dave Beck, executive vice president of the International Brotherhood of Teamsters, let it be known that his one-million-plus members felt the same way.

Open Break

It remained for "Big Bill" Hutcheson to make the most dramatic break. In a statement read at the AMA's Cleveland session last month, the 77-year-old head of the United Brotherhood of Carpenters and Joiners ripped the lid off union aversion to Ewingism.

Speaking for his 735,000 members (and also as first vice president of the AFL), Hutcheson flailed vigorously away at the Ewing scheme. "The backers of the national health plan," he said, "resent the term 'socialized medicine.' They have all sorts of arguments to 'prove' that doctors and patients will remain free as air . . . Perhaps if human nature were less ornery and less avaricious [such] an idealistic health program might work out all right.

"But so long as people have preferences—so long as Park Avenue has more appeal than Hell's Kitchen—there will be an uneven distribution of doctors under any plan

that does not contain compulsion. And once compulsion enters the picture, the rights and freedoms of *all* citizens stand in jeopardy. To me, it is as simple as that.

Rx for Bureaucrats

"If the day ever comes when Uncle Sam usurps the power to dictate to doctors, it will be a sad day for carpenters . . . I do not know much about doctors, but I know quite a bit about carpenters. They are an independent lot. They want to work where and how they please. The first bureaucrat who told a carpenter he had to work in Little Rock when he wanted to work in Lancaster would be gumming his food for lack of teeth.

"Carpenters want to be free agents . . . They will retain these freedoms only so long as all other groups retain theirs."

Hutcheson also did his bit to explode labor's notion that compulsory health insurance would be a good buy. "It looks cheap the way the backers present it," he said. "But when you dig down under the fancy layer of propaganda frosting, you find that it can be mighty expensive.

"The British people have already discovered this fact . . . Service that was supposed to cost £167 million per year [now] costs £484 million per year, and the end is not yet in sight . . . I am sure my poor old mother, who always made a dime do the work of a quarter, would not consider that kind of proposition any bargain."

The Hutcheson declaration may echo many times during 1951. Urban medical societies are already hunting around for labor leaders of like mind, then encouraging them to sound off in public.

Conclusive results may not show up for two years or more. But when and if labor's conversion is finally achieved, the health insurance fight will be over. That prospect should inspire a renewed burst of medical missionary work this year—especially among patients who wear overalls. END

Klocktomania

● The doctor had an inexpensive but charming little clock on his waiting room mantel. One day it disappeared. So he philosophically replaced it with a similar one. Next week a Mrs. K came in for her weekly visit, accompanied by her small son.

"Oh, look, Mommy!" he shrilled, in front of doctor, nurse, and other patients. "There's another clock like the one you got here last week!" R.N., TEXAS

Can We Rescue Our Medical Schools?

The AMA starts a dramatic campaign to refinance the schools without Federal aid

● The idea sprang from New England. It swept through AMA policy-making channels in a single day. It shows every sign of catching on with the profession at large. It may even touch off a national trend.

The idea is simply this: Let private physicians take the lead in wiping out medical school deficits. Let them stage a cash counter-offensive to the drive for Federal aid.

It's a tall order. The country's medical schools currently report operating losses that total about $10 million a year. Yet if only half the country's living physicians kick in $100 apiece, they can balance the books all by themselves. And indications are that they won't have to tackle the job alone.

Since the AMA announced its $500,000 pump-priming contribution, pledges have poured in from a variety of sources: pharmaceutical companies, medical publishers, equipment manufacturers, and the like. Once the campaign gets rolling, the AMA expects many unrelated businesses to chip in. The hoped-for goal: "Several million within a few months."

A group of Bostonians provided the initial impetus some months back. Their own medical school was wallowing in red ink. At an alumni gathering, they got talking about likely sources of new funds. "Look," one doctor finally said, "the best source of all is ourselves."

"How do you figure that?" another man asked.

Doctors in Debt

"Well, most of us are doing all right financially. Our medical school isn't. And one reason it's in a hole is that it gave us—free of charge—about three-quarters of our medical education. That's the part our tuition *didn't* cover. If we can bail out the school by repaying part of this debt, why don't we do it?"

The suggestion clicked. Almost without exception, the doctors present put up one or two hundred dollars apiece. Before the day was over, the school's financial future had begun to brighten. And the doctors were beginning to ask themselves, "If it works for one medical school, why not for all?"

That question bobbed up repeatedly last month at the start of the

* HANDITIP *

Switcheroo

I made a useful foot switch for my examining light by mounting an automobile floor switch (the kind that raises and lowers the headlight beams) on a small wooden box. On the side of the box are two electric plugs, one for my examining light, the other for a lamp giving general illumination. With sterile gloves on, or my hands full of instruments, I merely step on the foot switch to simultaneously darken the room and turn on my examining light; another toe-touch reverses the lights. The auto switch costs 85 cents.

—M.D., ILLINOIS

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AMA's Cleveland session. Dr. Elmer L. Henderson, association president, brought it into the open with a sharp warning to the delegates: "There are those who interpret the AMA's opposition to the bill for Federal aid to medical education as indifference to the problem . . . We must make it clear that the profession is *not* indifferent. Let us face clearly our obligation, individually and collectively, to provide significant financial assistance to the medical schools."

The same theme was wrapped up in resolutions introduced by Kansas and Oregon delegates. Sponsor Edward H. McLean of Oregon City summed things up this way: "Medical graduates, even though they have paid full tuition, contribute only 25 to 50 per cent of the cost of their education and therefore owe a moral debt to their medical schools. Many medical graduates recognize this moral debt and would be glad to discharge it in part after they become well established in practice."

Meanwhile, the Boston doctors were readying their own nudge. They drafted a resolution along the same lines, but with a new suggestion tacked on: that the AMA plank down half a million dollars of its own money on the medical schools' barrelhead.*

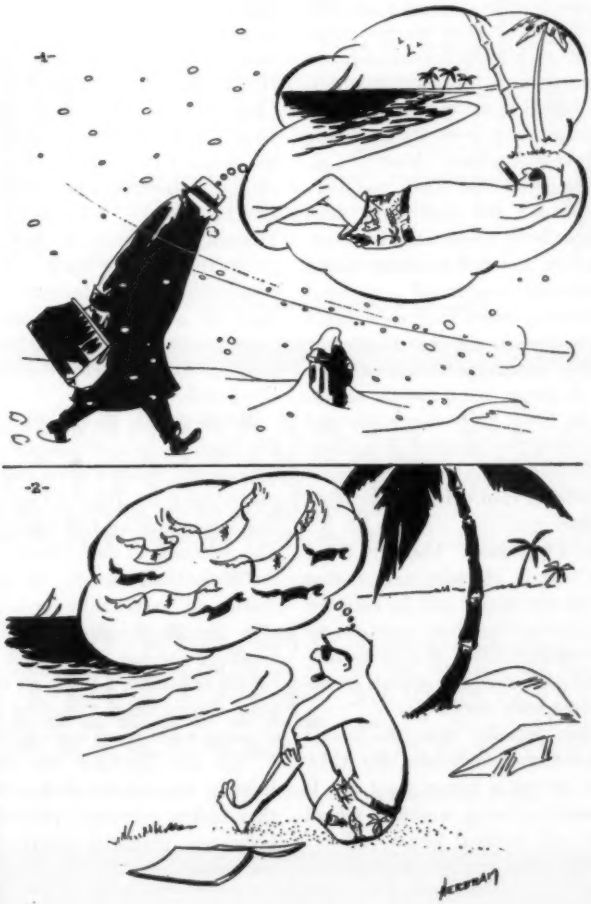
Before this resolution was introduced, AMA trustees got wind of it. Seldom have the holders of the association's purse-strings reacted more enthusiastically. They asked the sponsor for first crack at the proposal. They threshed it out at a late-afternoon board meeting on December 5, then called a special session of the House of Delegates early next morning. There Dr. Louis H. Bauer, board chairman, made the surprise announcement:

"The Board of Trustees has appropriated a half million dollars out of its National Education Campaign fund . . . for the aid and support of medical schools which are in need of additional financing.

*In the words of the resolution, "The Massachusetts Medical Society suggests to the Board of Trustees of the American Medical Association that a liberal amount of money (circa $500,000) be allocated from the National Educational Fund in 1951 for the medical schools of the United States."

This fund will be given to the medical schools for their unrestricted use in their basic training of future physicians.

"There is growing public awareness that Federal subsidy has come to be a burden, not a bounty. American medicine feels very strongly that it should not seek Federal aid for medical schools, unless all other means of financing have been exhausted . . . The AMA urges all its members to contribute individually to this cause. We hope



that doctors will take the lead in securing contributions from other sources."

What did the delegates think? A physician from New York sounded the keynote: "At last we have done something to dramatize our switch from the negative to the positive!" A Massachusetts medical man added: "It's about time we put some of that rock-throwing money to constructive use." A California delegate hailed it as "a great forward step—something even Oscar Ewing will have to applaud." Another Californian noted that AMA members who haven't yet paid their dues will now have new reason to do so.

Though the AMA action would undoubtedly trigger off a national fund-raising effort, the association's officers weren't sure last month just how the campaign would be handled. A group being quietly organized in New York—the National Foundation for Medical Education—might eventually direct it. But for the present, the AMA was running the show.

Said Dr. Bauer: "The only thing we're certain of right now is that none of the money will be used for the administrative expenses of fund-raising. All of it will be funneled to the medical schools in accordance with need."

What, exactly, *was* the need? That, too, was something the AMA hoped to get a better slant on. It planned to bring medical school deans and medical society officers together for a realistic appraisal of requirements. One starting point might be the schools' operating deficits (about $10 million a year). Another rough yardstick might be the operating grants proposed in the various Federal aid bills (about $12.5 million a year).

The most generous yardstick—and the AMA could be counted on to examine it with a critical eye—was set up last year by the Public Health Service Surgeon General's Committee on Medical School Grants and Finances. This committee, headed by Lowell J. Reed, included such physicians as Robin C. Buerki, George Baehr, Hugh J. Morgan, and Ernest E. Irons. The group reached the eyebrow-raising conclusion that "Medical schools need an additional $40 million a year in current operating funds to perform their existing functions adequately."

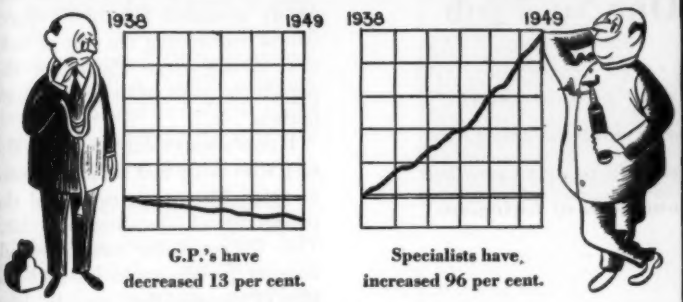
Whatever the need turned out to be, there was a reasonably good chance the AMA's new campaign could meet it. That, at least, was the consensus at Cleveland. Said one delegate as the session ended:

"We raised nearly $5 million within our own ranks for a defensive campaign against compulsory health insurance. Now that we're on the offensive, I think we can do even better. And this time, for a change, we have no real opposition.

"No one opposes the idea of helping the medical schools. So that makes everyone—physician or layman—a potential contributor to our cause." END

Accent on Specialism

Latest figures show fewer G.P.'s, twice as many specialists as in 1938



G.P.'s have decreased 13 per cent.

Specialists have increased 96 per cent.

(Physicians in general have increased 9 per cent.)

3 out of 15 physicians were specialists in 1938.

More than 5 out of 15 physicians were specialists in 1949.

The term "physicians," as used here, means those in active, private practice. "G.P.'s" include part-time specialists. Source: American Medical Association. Chart copyright 1951, Medical Economics, Inc.

Health Insurance: Our No. 1 Job

AMA president-elect describes the things we can do to avert another outbreak of Ewingism

● Prepaid health care has developed so rapidly that it has surprised everyone—including the physicians. Ten years ago, comparatively few Americans carried any sort of health insurance. In one decade, the enrollment figure has gone beyond 70 million.

Why?

One reason is the obvious wisdom of protection against the costs of illness. Another is the power of publicity. Physicians have done much to unleash this power in behalf of voluntary health insurance. Yet even physicians tend to underestimate the results it can bring.

This was called to mind a few weeks ago when a reporter asked me to comment on a statement supposedly issued by the AMA in 1934. "Without some form of compulsion," the association had said, "voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population with even approximate fairness . . ."

It now seems clear to me that the men who made that statement were in error. They underestimated the possibilities of educating the public. They did not realize how many millions of people could be sold the idea of insuring their own health—voluntarily. Nor did anyone else.

Why was this? Perhaps because no one could foresee how our profession would react to the threat of socialization. We reacted with an unprecedented promotional effort that helped lift prepay enrollment to record heights.

Doctors Under Pressure

My home state of California is a case in point. Ten or twelve years ago, when political agitation for state-wide compulsory health insurance began, less than 2 million people in the state had any form of health protection. But the more the politicians agitated, the harder the

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**Dr. John W. Cline, who prepared this article expressly for* MEDICAL ECONOMICS, *takes office this coming June as the one hundred and fifth president of the American Medical Association.*

doctors worked at the job of boosting the voluntary plans. Today some 6½ million Californians are enrolled—many more than the politicians promised to cover.

That same phenomenon is being duplicated on a national scale. Messrs. Murray, Dingell *et al* did the promising; but doctors, hospital people, and insurance men have actually delivered. Today more people are enrolled in the voluntary plans than would be covered at first if the Administration's health scheme were enacted.

Improvements Needed

While the voluntary plans have done a wonderful mass-selling job, quality of coverage has sometimes lagged behind. Considering their rate of growth, this is natural enough. Nevertheless, one of the great tasks that now lies before us is to raise the level of health protection offered. We must push harder, for example, on such improvements as these:

1. More liberal membership privileges. The medical-society-sponsored plans have set the pace in this realm. Many of them, for example, now enroll individuals as well as employed groups. But there are still some that do not.

Consider, too, the case of subscribers who reach the age of 65. Some plans automatically drop such people from their rolls as bad risks. This terminates protection at a time when it is needed most.

There is no way at present of insuring these people as *new* subscribers; the cost would be prohibitive. But with the increasing life span, it is essential that we offer present subscribers coverage after 65. Many plans already do so. All should.

2. Full-service benefits for subscribers of modest means. About three-quarters of the Blue Shield plans already operate on this basis. People whose incomes are below a specified ceiling thus pay nothing extra for services provided through the plan. But the remaining quarter of the plans still restrict their benefits to cash indemnities—which may or may not cover the subscriber's sickness bills.

Such plans, in my opinion, fail to capitalize on the most appealing

feature of Blue Cross and Blue Shield—the thing that sets our medically-sponsored plans apart from all others. Low-income subscribers should not be exposed to the possibility of surcharges when they need medical care or hospitalization. Nor are they so exposed in the great majority of our plans.

3. *Protection against long-term ills.* This is important. California Physicians' Service has found, for example, that only about 2½ per cent of its subscribers require as much as three weeks' hospitalization in one year, and that only a small fraction of 1 per cent require more than six weeks' hospitalization. Yet everyone is fearful that *he* may end up in that unlucky group. It is to allay this fear that we need to offer catastrophic coverage much more widely.

We must not forget that our plans must stay actuarially sound—something the politicians do not have to worry about. That means the newer plans will not be able to offer catastrophic coverage at this time. But the older and bigger ones can well afford to experiment. Some are now preparing to do just that.

Where Freedom Lies

All three of the improvements I have mentioned here—and, in fact, nearly all other problems in modern medical economics—require collective action on the part of our profession. To some physicians, this is a disturbing trend. What, they ask, is happening to the individualism that made our profession great?

My father was a physician and an individualist. I remember when industrial insurance came in, he said no insurance company was going to tell *him* how to practice medicine. Yet he found that the companies desired good medical care and did not interfere with him in providing it. He learned to cooperate with them. He realized—as we all must—that our profession's future depends on intelligent group action. Only by such means can we retain our traditional freedom.

What is our profession's future? I see it as linked inextricably with voluntary health insurance. It is my firm conviction that our record-breaking enrollment pace will be maintained until we reach a still-undetermined saturation point; that within a few years the vast majority of self-supporting Americans will be covered.

John Q's Attitude

Along with this development will come a marked improvement in the *quality* of coverage. When the low-income worker has had sufficient opportunity to get top-quality insurance at reasonable cost, I believe he will make the most of that opportunity. In time, he may even feel that if his neighbor is not covered, it is his own fault.

If this seems unlikely, consider the present-day attitude toward a man who fails to take out fire insurance and whose house burns down. No one bewails the fact that the

Hey, Hurry Up With That Lightning Rod!

Government has not protected him. Everyone recognizes that it is his own responsibility. So, in time, it may come to be with health insurance.

As both quantity and quality of prepaid health contracts continue to rise, the idea of Government health insurance will progressively lose its popular appeal. This has already happened to a marked degree.

Look at the November election results. An impressive percentage of candidates who favored Government health insurance were beaten. At least some politicians of this stripe have come to wonder if they were not backing a poor cause.

There has been a change in the attitude of some labor unions. They are increasingly skeptical of Federally-run programs, having found (in such projects as TVA) that Government control can hurt *union* freedom. Many important labor groups have quietly come over to the voluntary way, at least to the extent of enrolling their members in voluntary plans.

Events are beginning to turn in our favor, but we must not get the idea the battle is won. ***It is not.***

Remember the post-election glow of 1946? Too many doctors cheered, then sat back and relaxed. We had a job to do with the voluntary health plans, but we did not do it properly. We should have prepared for renewed onslaughts of the socializers, but we did not. Result: a virulent outbreak of Ewingism in 1948-1950.

I believe we can prevent another flare-up. We can prevent it by throwing our full weight behind a concerted drive to strengthen the voluntary plans. We have perhaps two years to prove our case. But let us not deceive ourselves:

We must prove it not in what we *say*, but in what we *do*.

—JOHN W. CLINE, M.D.

Just Plain Considerate

• When I ran into her on the street recently, the lady was obviously pregnant again. A year earlier she'd been my first maternity patient in my new location, and I'd done my utmost to please. However, I'd neither been paid nor heard from her since.

"Oh, good morning, Doctor," she blurted. "I do want you to know how well satisfied I was with your services last time. I'd have come to you again, only I didn't think it was fair to owe so much to one doctor. Now I owe smaller bills to several doctors."

—ERNST BURIAN, M.D.

New Power at the Polls

America's medical men were rank amateurs in politics —but look what happened

• Like many another U.S. physician, Howard F. Conn had always looked on election campaigns as something vaguely obscene. In Uniontown, Pa., where he'd practiced internal medicine since World War II, he rarely talked politics with his friends, and never—but never—with his patients.

Then came the great election fever of 1950. On Sunday, November 5—two days before the balloting—Howard Conn caught the bug.

He drove purposefully out to the local airport. His own plane, a trim Cessna he'd learned to fly under the G.I. Bill, was gassed up and ready. Though it was supposed to be a two-seater, there was barely room for him to squeeze in behind the controls. Every other cubic inch was jammed with small bundles of yellow-and-black leaflets—50,000 of them, in all.

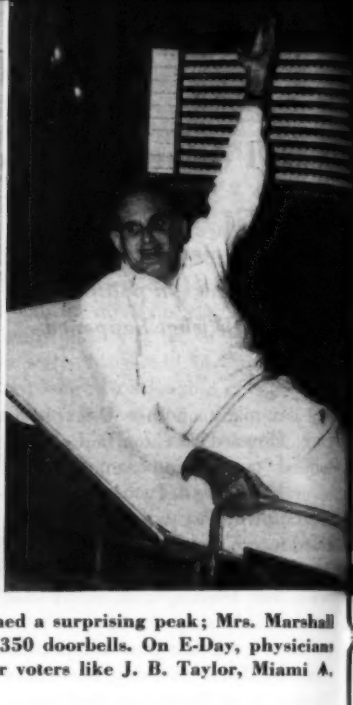
Dr. Conn revved up, took off, and climbed to 1,000 feet. For the next three hours, he wheeled and turned above the small mining towns that dot the Western Pennsylvania coal country—Grindstone, Mill Run, Fairchance, Outcrop, Oliphant Furnace, and such. Over each cluster of houses, he tossed out a handful of leaflets and watched them flutter to the ground.

Why this strange mission? Dr. Conn's leaflets spoke for themselves: "Compulsory national health insurance would increase your taxes, cut down your take-home pay . . . Cavalcante is FOR compulsory national health insurance. Sittler is AGAINST it. Vote for your friend, Edward Sittler."

Two days later, the people did. U.S. Congressman Anthony Cavalcante, the Democratic incumbent in a strongly Democratic district, went down to a stunning defeat. What licked him was in large part the pulse-quickening campaign put on by local professional men—a campaign in which Dr. Conn's flight added some notable upstrokes to the fever chart.

Political Awakening

This sort of thing happened all over the United States. Physicians were utter neophytes at the game, but they got fired up as never before. They had a cause that caught people's imagination. They campaigned with astonishing vigor and



Electioneering by doctors' wives reached a surprising peak; Mrs. Marshall Nims of Denver A rang a total of 1,350 doorbells. On E-Day, physicians arranged ambulance rides to polls for voters like J. B. Taylor, Miami A.

ingenuity—as witness this cross-country sampling of the strategies they used:

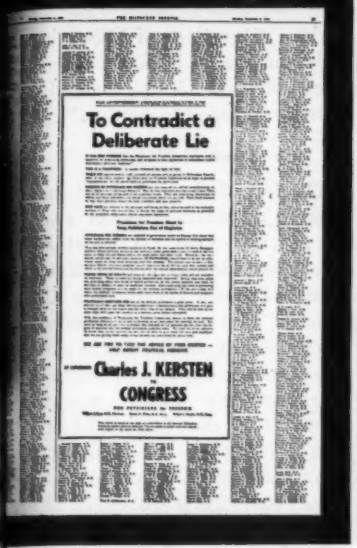
¶ In Indianapolis, medical leaders bought large batches of the Democratic National Committee's rosy-eyed booklet on compulsory health insurance, mailed a copy to every physician in the state. Aim: "to put the doctors in a fighting mood."

¶ In Syracuse, N.Y., where about one physician out of every three usually failed to vote, an all-out registration drive coasted to success on the strength of the theme, "Help find the third man."

¶ In Denver, the doctors' wives put on a spirited door-to-door campaign; during the final weeks, one enthusiastic helpmeet called on 450 different families three times each.

¶ In Omaha, hospital staff men put a persuasive campaign appeal on each new patient's breakfast tray.

¶ In Chicago, thousands of doctors and druggists slapped campaign stickers on every bottle of medicine dispensed.



Paid ads, like this one ▲ sponsored by Milwaukee professional men, sparked many of medicine's campaigns. A more unusual stunt was the leaflet-dropping mission flown by Dr. Howard Conn of Uniontown, Pa. ▲

¶ In Milwaukee, physicians sponsored full-page newspaper ads the day before the balloting. They listed the names of 900 campaign contributors (all M.D.'s), urged local citizens to "take the advice of your doctor."

¶ In Columbus, Ohio, the families of medical men formed a baby-sitters' brigade, offered free service to voters on election day.

¶ In Miami, funeral directors were persuaded to organize an election-day motorcade, using ambulances and even a few hearses for getting bedridden patients to the polls.

¶ In downstate Illinois, physicians closed their offices on E-Day to dramatize their protest against "the threat of socialized medicine."

Healing Arts Unite

All over the country, medical men gave original twists to such campaign ideas. They banded together as bipartisan "healing arts committees," divorced from their medical societies and from the AMA. They enlisted the help of

dentists, pharmacists, nurses, chiropodists, optometrists, medical secretaries, hospital workers—and their wives. They donated large quantities of time, money, and hard work—which, as any ward boss will tell you, is what usually swings elections.

Did it swing this one? The record stares you in the face. Most Congressional candidates who'd been favorably disposed toward compulsory health insurance felt obliged to renounce it during the campaign. Of the handful of Ewingites who refused to back down, nearly 90 per cent got licked at the polls.

Late disavowals weren't enough to save several candidates from the doctors' wrath. Senator Scott W. Lucas, for example, tardily broke the news that he was "utterly opposed to socialized medicine in any form—and that includes compulsory health insurance." Unconvinced, most Illinois doctors went on working for Everett Dirksen, who won. In Pennsylvania, Senator Francis Myers made the same eleventh-hour break with Ewingism—and lost.

And Sudden Death

What happened to the official sponsors of the national compulsory health insurance bill? Five were up for re-election; four of them bowed out. Rousing campaigns by the doctors helped retire Senator Elbert Thomas of Utah, Senator Claude Pepper of Florida, Senator Glen Taylor of Idaho, and Representative Andrew Biemiller of Milwaukee. Only the crafty John D. Dingell, representing a CIO stronghold in Detroit, managed to survive.*

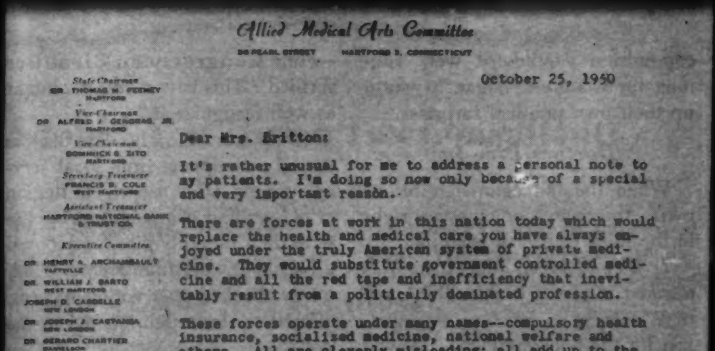
How It Began

The fuse that touched off these assorted detonations was lit a year ago in Jacksonville, Fla. Local physicians had gathered for a talk with Claude Denson Pepper, the U.S. Senate's most articulate champion of compulsory health insurance. The discussion got nowhere; tempers wore thin. Finally Senator Pepper told the doctors bluntly: "I'm sticking by the Administration's health plan. I just don't care about your 2,000 votes in this state."

In the spring of 1950, Florida medicine flared back. Doctors all over the state chipped in $100 apiece; their wives staged parties to raise more. Political action committees in every county rallied behind 37-year-old George A. Smathers and went after Pepper in the Democratic primaries.

Professional reserve melted away. Doctors got out their patient lists, dashed off hundreds of personal letters. From Tallahassee to Ponce de Leon, people began to tell each other, "My doctor thinks it's a good idea to vote for Smathers." Some patients wrote answering notes that gave M.D.'s a rare glimpse of their

*Not up for re-election in 1950 were three other sponsors of the compulsory health insurance bill: Senators James Murray of Montana, Dennis Chavez of New Mexico, and Hubert Humphrey of Minnesota.



Allied Medical Arts Committee

50 PEARL STREET HARTFORD 3, CONNECTICUT

State Chairman
DR. THOMAS M. FEENEY
HARTFORD

Vice-Chairman
DR. ALFRED J. GENDRAU, JR.
HARTFORD

Vice-Chairman
DOMINICK S. SITO
HARTFORD

Secretary-Treasurer
FRANCIS B. COLE
WEST HARTFORD

Assistant Treasurer
HARTFORD NATIONAL BANK & TRUST CO.

Executive Committee
DR. HENRY A. ARCHAMBAULT
PUTNAM
DR. WILLIAM J. BARTO
WEST HARTFORD
JOSEPH D. CASSELLE
NEW LONDON
DR. JOSEPH J. CASTANIA
NEW LONDON
DR. GERARD CHARTIER
DANIELSON
FRANCIS B. COLE
WEST HARTFORD
MRS. ROBERT J. COOK
NEW HAVEN
DR. W. G. H. DOBBS
TORRINGTON
DR. WILLIAM B. DUBLEAVY
NEW HAVEN
DR. THOMAS M. FEENEY
HARTFORD
DR. ALFRED J. GENDRAU, JR.
HARTFORD
DR. WILLIAM GRAY, JR.
PUTNAM
DR. NORRIS A. HASKIN
NEW HAVEN
DR. HARRY C. KNIGHT
MIDDLETOWN

October 25, 1950

Dear Mrs. Britton:

It's rather unusual for me to address a personal note to my patients. I'm doing so now only because of a special and very important reason.

There are forces at work in this nation today which would replace the health and medical care you have always enjoyed under the truly American system of private medicine. They would substitute government controlled medicine and all the red tape and inefficiency that inevitably result from a politically dominated profession.

These forces operate under many names--compulsory health insurance, socialized medicine, national welfare and others. All are cleverly misleading; all add up to the same result--government control. If they succeed, you will be compelled to accept medical, dental, pharmaceutical and nursing care as dictated by the government.

We of the medical arts are determined they will not succeed. We have organized the Allied Medical Arts Committee. For the first time we will take an active part in a Connecticut political campaign so that we can help the election of candidates who will consistently oppose these forces. We have studied the records and the attitudes of the Democratic and Republican candidates on this vital issue. As a result, we have unanimously endorsed the following:

Most effective of the doctors' vote-winning devices was the personal letter to patients. This one, used in Connecticut, endorsed both Democrats and Republicans who would "resist government control of medicine."

own influence: "Didn't know you were interested in this man—I assure you I'll vote for him" . . . "Received your card and am going to please you. Hadn't even planned to register."

On election day, medical workers phoned every professional man in the state before noon. More than 70 per cent, they found, had already voted. In some small towns, every phone number in the book was called. By the time the primary balloting was over, George Smathers was a shoo-in.

Said Dr. Edward R. Annis of Miami, a leader in this uprising: "We were amateurs in a new field. We made many mistakes; but we worked hard, we learned much, and we were victorious—against almost inconceivable odds . . . No politician running for office in this state will ever again discount the power of the physicians."

Sparks from the Florida flare-up were wafted as far north as Wisconsin, as far west as California. Medical men in those regions—and in some dozen others where pro-

compulsion candidates were running for Congress—began to warm up their own political surprises.

Doctors Dive In

When the fall campaign hit its peak, American medicine was right in the thick of it. For example:

1. Biemiller vs. Kersten in Milwaukee. Andrew J. Biemiller came to Wisconsin in 1932 as an organizer for the Socialist Party. He won election to the legislature, made several abortive attempts to bring Wisconsin citizens an ersatz brand of state medicine. Then he graduated to Congress, where (in his own words) he eventually became "the Administration's floor manager for health insurance—a highly unusual honor for a second-term Congressman." He also became a high-pitched critic of the medical profession, whose leaders he described as "a unique combination of selfishness, obtuseness, and a kind of paranoid malice."

Opposing him in the 1950 elections was former Congressman Charles J. Kersten, who announced early in the game: "Compulsory health insurance would destroy the finest part of American medical service; its evils would fall most heavily on the American workman . . ."

Thus the battle lines were drawn. Milwaukee's professional men scrambled for the Kersten side. Drs. William Egan, Dexter Witte, and William Murphy set up a group known as "Physicians for Freedom"—while Congressman Biemiller shrilled, "This is war and we might as well recognize it."

It was war, all right. The doctors stirred up support from local service groups (the American Legion *et al*), stuffed campaign appeals in with their monthly bills, and loosed a barrage of personal letters. Their wives checked past voting records, offered to drive delinquents to the polls.

Biemiller charged that Physicians for Freedom was an insignificant medical minority. The group countered with full-page ads "To Contradict a Deliberate Lie." The ads listed the names of nearly all Milwaukee medical men, wound up: "We ask you to take the advice of your doctor. Help defeat political medicine by returning Charles J. Kersten to Congress."

Not all the doctors listed actually supported Kersten. One, in fact, had been dead since March. Another said he intended to vote for Biemiller. A third, Dr. Arthur Hankwitz, commented wistfully. "I want to be neutral in this campaign. I've got patients who are Democrats, Republicans, and Socialists; they can vote as they please without any pressure from me."

But almost everywhere else in Milwaukee, the pressure was enough to shatter a sphygmomanometer. On November 7, it shattered Congressman Biemiller's immediate future. Kersten was elected by a sizable majority that cut across party lines. [*Continued on* 207]

Should You Hire a Tax Consultant?

This doctor did, and got a big surprise as well as a sizable tax saving

● Not every tax consultant will go so far as to hurry up your marriage in order to save you taxes. But mine did. Grateful was a mild word for my feelings—and not only for the bonus of extra months of marriage. By that and more conventional devices, my expert saved me more than half the Federal income tax I'd have otherwise paid.

I *know*, because I first tried to figure out my 1949 tax on my own. Muddling through alone, I'd have been taken by the tax collector for a total of $13,752. As it was, my tax liability was reduced—thanks to good advice—to $6,862.

Maybe you're thinking that taxwise I must be pretty dumb. True, I'm no Einstein. Yet my 1949 experience might have thrown a smarter man than I for a tax loss. Take a look at my situation:

I'm a specialist, age 43, with a good practice. I have one son in his teens. Early in 1948, my wife died. When her estate was settled in May 1949 I found myself owner of a valuable piece of land, some corporate stocks and Government bonds. With my sister- and brother-in-law, I also became one-third owner of an apartment house.

Right away, I sold the land because I wanted cash to buy a place that would serve me as home and office. That sale gave me a long-term capital gain of almost $18,000. It was then that I started worrying about taxes. Capital gains, my share of the apartment house income, dividing my new home into part residential, part professional use—these were a complicated business all right; but I did my best and projected my estimated income for the year.

All the deductions and exemptions I could tot up came to only $3,260. My net income would be $37,090; my taxable income—$33,830. Wow!

Enter the Consultant

A friend rescued me. He suggested putting the whole mess up to a good tax consultant. Which I did, with the following happy results.

At once, the consultant began whittling away at every item. Among the dividends I'd listed, was one for $240 from a life insurance policy. It was non-taxable. Another

* HANDITIP *

Color Cue

Each year, starting January 1, I change the color of ink used for my office records, correspondence, and so on. Thus, a mere glance tells me the vintage of any paper or document in my files.—M.D., KENTUCKY

* * * * *

$90 in interest from Treasury bonds, which I bought before March 1941, was also tax-free.

I'd overlooked some obvious professional expenses. Like a ferret, the tax man was after them. In doing a research job for a chemical plant, I'd had slides prepared and typing done. That was $120. Other items—none large—totalled $700 more. All of which reduced my net professional income.

Taking a Loss

There were losses I should have taken and didn't. I have—or had—a 20-foot motorboat. In April, a storm tore it from its mooring and it sank forever. I had partial insurance, of course, but I still took a net loss on the boat of $900.

When I sold my car that I used solely for professional purposes the loss was $700; but I had mistakenly taken only 50 per cent. This automobile, my advisor pointed out, was a non-capital asset. I could claim full loss.

I'd been in a big hurry to sell the inherited land at its high value. As for the inherited stocks, I'd forgotten them. Their market price was down, their future dim. Why not sell them? I did so in December, and earned, so to speak, a nice long-term capital loss of $2,400.

Then we tackled my new, unfamiliar job as landlord. Why shouldn't the three of us who owned it form a partnership? There were many advantages to such an arrangement, but the main point was this: As a partnership, that operation would be declared for the fiscal year, ending May 15, 1950. No part of the income (which turned out to be $1,600 in my case) had to be declared by any of us in 1949.

By this time, with my head well out of water again, I was feeling exuberant. But there were more savings to come. A lot of new furniture went into my new home. The state sales tax on it had slipped my mind. We figured that at $70 and deducted it.

One boner turned up that I still blush about. During the summer, my son had earned $385 running errands and clerking for a local grocer. Without thinking, I declared his income with mine. My consultant chuckled and pointed out that this was less than $500, therefore not taxable. Moreover, the boy was a minor. Why hadn't I claimed him for a dependent exemption of $600?

By now, my rehabilitated return showed that I would owe $9,878—a neat saving of $3,874. (Part of this was saved by using the alter-

nate method of computing for long-term capital gains. This is possible for anyone whose net income after exemptions exceeds $22,000 if he has only long-term gains—or if his short-term losses are less than his long-term gains. It allows you to add 50 per cent of such net capital gains directly to your tax based on ordinary income, instead of adding net capital gains to net income and computing your tax on that amount.)

I was perfectly happy, but my adviser was still not satisfied. A curious look came into his eye. I wasn't thinking of remarrying, was I?

As a matter of fact, I was—but not till the following March. Would the bride-to-be consider a late 1949 marriage? She would. We were married on Christmas Day. I didn't realize the full virtue of this inspired change of schedule until afterward.

By recomputing my tax, using such advantages of the married state as the joint return, split income, additional exemptions, and deductions, my cupid-consultant reduced my tax by another $3,016—a really handsome wedding present.

Naturally, I'm prejudiced. You won't often get a tax consultant who'll serve as marriage broker too. But, if I'm any kind of sample, he'll at least save you money.

—ANONYMOUS

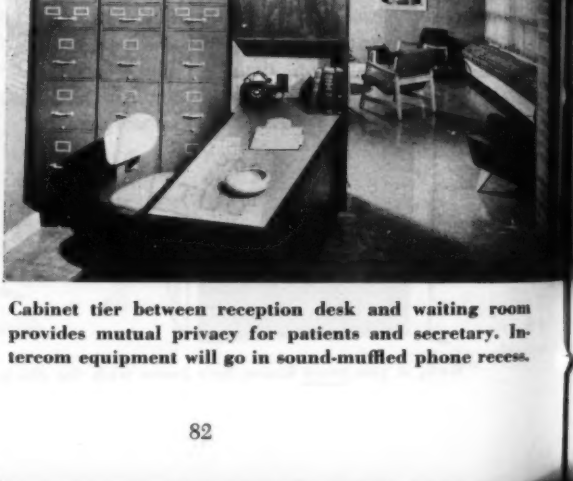
"Well, if you must know, he's home with the chicken pox."

Space-Saving Office for Two

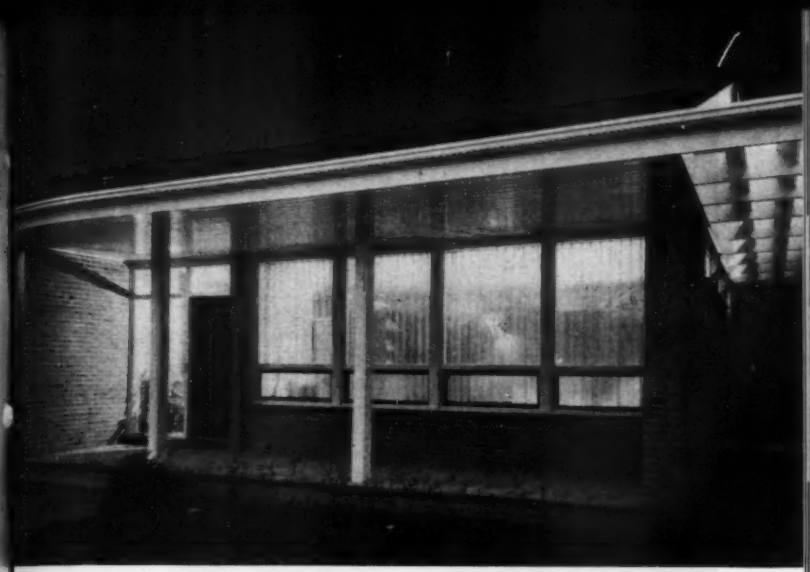
• Adapting his ideas to the character of his neighborhood (conservative residential) and to the limitations of his lot (50′ x 100′) took a bit of doing. But the result—the medical office shown here—was worth it, says Dr. Sanford M. Lewis, a Newark (N.J.) internist.

Aided by Architects Allen and Edwin Kramer, he arrived at a modern, one-story design. The lines of the building are softened by such traditional touches as a sloped roof and a flagged walk.

Besides Dr. Lewis, the office accommodates a tenant M.D. Each man has his own consulting-examining suite, with easy access to laboratory, X-ray, and basal metabolism rooms (see floor plan on page 84).



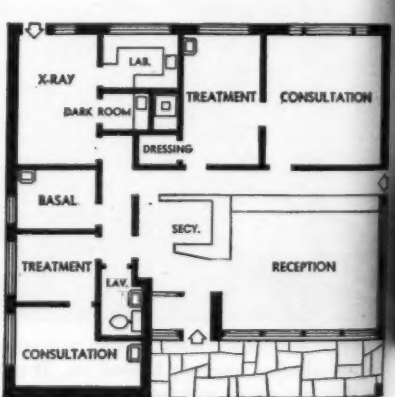
Cabinet tier between reception desk and waiting room provides mutual privacy for patients and secretary. Intercom equipment will go in sound-muffled phone recess.

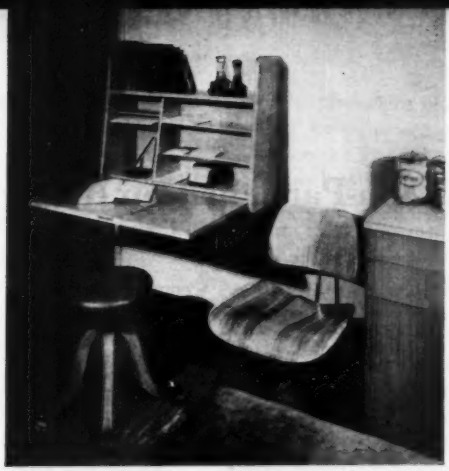


Waiting-room coat closet is also accessible from corridor of clinical section behind it. Departing patients can thus get wraps without returning to reception room.

Draperies in this consultation room [▲] conceal picture window. Plan [▼] shows these noteworthy features: private side door for doctor, lavatory next to reception area, storage wall between reception room and corridor. Latter idea eliminated need for closets, saved thirty-five square feet of floor space.

Space-Saving Office for Two *(Cont.)*





Examining-room desk is handy for on-the-spot notes, closes up when not in use. Door at left leads to dressing cubicle. Out of picture at right is handy pass-through window to laboratory.

Consultation-room bookshelves are adjustable in height. Rear wall, finished in tan burlap, matches carpeting and contrasts with walnut paneling of other walls, adding a touch of softness. **END**

Would Non-Participation Really Work?

If U.S. doctors ever mobilize against a Government medical system, here's the master plan they'll probably use

● "Government-controlled medicine? Not a chance. We doctors don't have a thing to worry about this year."

So spoke an ebullient young Texan we know. Whereupon an older colleague cut him down with a sharp, "What about next year? And the year after that?"

Thoughtful physicians are well aware that they've won a battle but not the war. So in their campaign against Federal medicine they're casting about for potent new weapons. They're even giving some thought to the most potent weapon of all: non-participation.

Critics have called it "a strike against the sick public." It is not. It is, instead, a refusal to take part in a particular method of delivering medical care—in this case, compulsory health insurance. The plan calls for doctors to stay aloof from any such scheme; to provide all needed medical service; but to treat all comers as private patients, not as beneficiaries of the Government system.

Across the Atlantic, non-participation may get an early test. After thirty months of the National Health Service, some 20,000 British G.P.'s are threatening to withdraw. But on-the-scene observers have their doubts about the potency of this threat. One Londoner says flatly: "Nothing will come of it. The doctors organized too late."

By preparing now, could American doctors successfully resist a Government-controlled medical system?

Approved in Principle

Most private M.D.'s are probably resistance-minded. Three years ago, MEDICAL ECONOMICS asked 4,864 of them the following question: "Would you participate in the Wagner-Murray-Dingell program if

---

**This article tells how a coordinated program of non-participation might be put into effect, as envisioned by the Association of American Physicians and Surgeons. What do you think of the plan described here? Your opinions are invited for possible use in a forthcoming sequel.*

it became law?" Here's how their answers broke down:

Yes	15%
No	61
Undecided	24

But even if non-participation is approved in principle, the question remains: "How *practical* is the idea?"

If any group can answer that, it would seem to be the Association of American Physicians and Surgeons. For ever since its founding in December 1943, the AAPS has said its No. 1 objective is "To organize physicians to agree to participate only in those methods of rendering medical service which are in the public interest . . . "

To find out specifically how the association would go about this job, MEDICAL ECONOMICS asked AAPS directors twelve questions. Their answers follow, verbatim. Read them and judge for yourself the practicability of non-participation:

Q. What is the nub of the non-participation plan?

A. The AAPS proposes that physicians exercise their Constitutional right not to take part in schemes for the distribution of their services that are contrary to the public interest. It is a proposed action of morality by ethical physicians, designed to protect the people from inferior medical care. We believe, therefore, that the plan would win sympathetic public support.

Dr. Amos R. Koontz, public relations chairman of the Baltimore City Medical Society, states it clearly: "The physicians of this country do not have to accept socialized medicine . . . The Government may pass the law and tax the people, but it cannot force physicians to give up their private practices and become Government employes . . . "

Non-participation is both simple and legal ("There shall be no involuntary servitude"). Physicians would continue to serve their patients just as they do now.

Q. How would non-participation pledges be secured from the profession at large?

A. Since organization of the AAPS, physicians from every state —in fact, from every city of appreciable size—have joined. These members (along with sixteen state medical societies and more than 300 county societies) have explicitly approved AAPS objectives, including non-participation. Such doctors would serve as Minute Men. We believe they could enroll 90 per cent of the nation's eligible physicians within forty-eight hours if threatened by passage of a socialized medicine law.

Q. What specific moves would be made to assure good public relations?

A. The nation's press and radio would carry paid advertising explaining why doctors refused to become pawns of a political bureaucracy. The most effective public relations work, however, would be carried on at the level of the individual doctor.

Q. Who would spearhead the

now to sleep—
perchance to dream
undisturbed
by night-time **itch**

EURAX®

ANTIPRURITIC CREAM

EURAX antipruritic cream, applied to the itching area before retiring, is your patient's best assurance of a full night of undisturbed sleep.

A totally new antipruritic . . . EURAX, original product of Geigy research . . . sets new standards in the treatment of pruritus. In a carefully controlled study[1] EURAX provided "excellent (complete) relief" in 66.2 per cent of cases, and "moderate (considerable) relief" in 27.4 per cent. In most instances a single application ensured relief for 6-8 hours or more. In no case did the cream lose its effectiveness on continued application.

Not an antihistaminic . . . not a -caine derivative . . . not a phenol preparation . . . EURAX gives quicker, longer-lasting itch control with notable absence of local irritation, sensitization or systemic toxicity.[3]

As a specific in the treatment of scabies EURAX Cream in a single application eradicates the infection in over 90% of cases.[2] A second application gives practically a 100% cure rate.[4] No prior bathing or scrubbing required. Bacteriostatic, EURAX accelerates healing in infected scabies.

1. Cooperus, M.: J. Invest. Dermat. *13*:35, 1949.
2. Patterson, R. L.: Southern M. J. *43*:449, 1950.
3. Peck, S. M. and Michelfelder, T. J.: New York State J. Med. In press.
4. Tronstein, A. J.: Ohio State M. J. *45*:889, 1949.

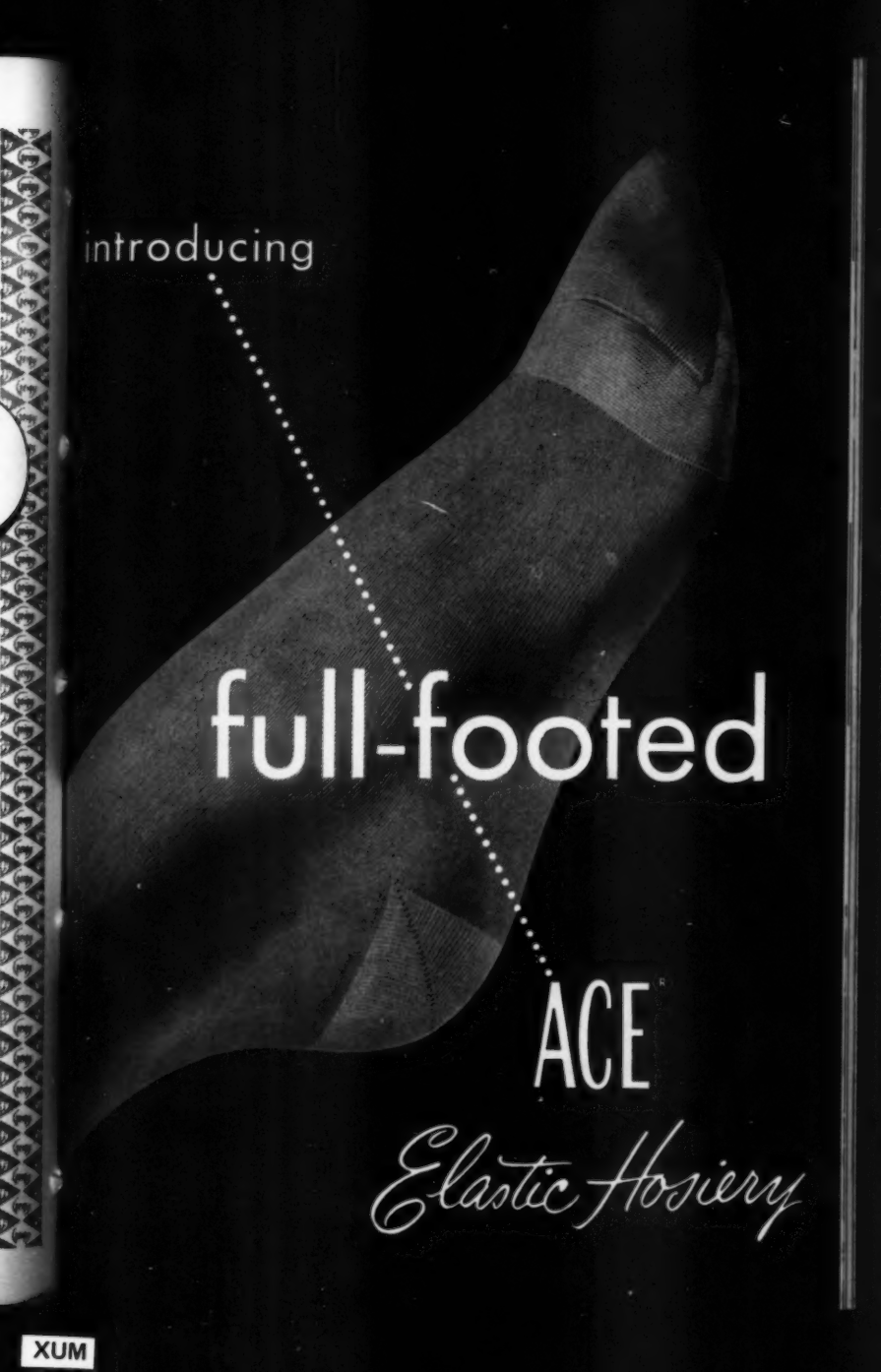
Geigy

EURAX (brand of crotamiton) Cream: 10% N-ethyl-o-crotonotoluide* in a vanishing cream base supplied in tubes of 20 Gm. and 60 Gm. and jars of 1 lb.

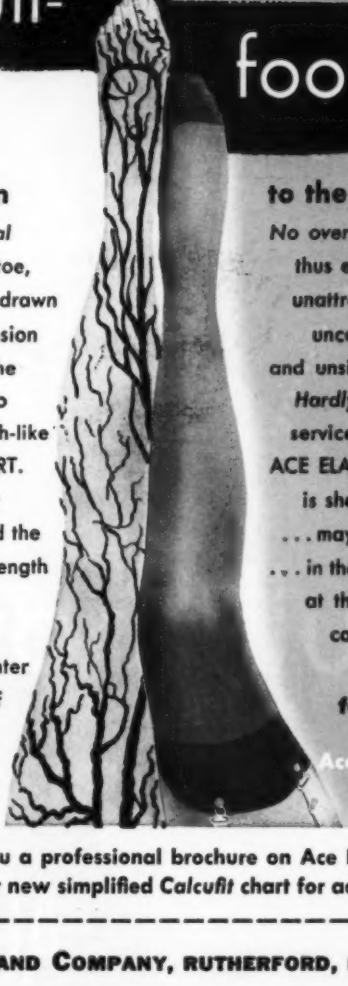
*U. S. Pats. #2,505,681 2,505,682

E-19

GEIGY CO., INC., Pharmaceutical Division, 89-91 Barclay St. • New York 8, N. Y.



full-footed means...



to the physician

Positive terminal anchorage at the toe, enabling hose to be drawn on the leg under tension and fastened at the cuff to garters to give a unique sheath-like SUSPENSION SUPPORT.

Resulting two-way pressure . . . around the leg and along its length . . . provides greater support to the leg structures with lighter weight hosiery knit of nylon-covered rubber thread

to the patient

No overhose required, thus eliminating unattractive bulkiness, uncomfortable weight and unsightly wrinkles.

Hardly discernible from service weight nylons, ACE ELASTIC HOSIERY is sheer and form-fitted . . . may be worn anywhere . . . in the office, shopping, at the theatre, in comfort and in style.

fashioned by B-D makers of Ace Elastic Bandages

May we send you a professional brochure on Ace Elastic Hosiery together with our new simplified *Calcufit* chart for accurate fitting?

BECTON, DICKINSON AND COMPANY, RUTHERFORD, NEW JERSEY

Please send me FREE Professional Literature and Calcufit charts for ACE ELASTIC HOSIERY.

Dr._____

Street_____

City_____ Zone____ State_____

proposed mass enrollment effort?

A. Probably AAPS officers and directors.*

Q. When and how would the start of the non-participation program be announced?

A. As soon as a poll of all AAPS members showed that a majority considered a certain medical care program to be "inimical to the public interest," non-participation would become mandatory for each AAPS member. A date would then be set on which this action would be implemented.

Q. What specific steps would be taken to assure maximum professional support?

A. AAPS leaders in every county medical society would call emergency meetings. At these meetings, members would renew their pledges and map out detailed plans for non-participation.

Q. What could be done about backsliders?

A. We hold that the number of backsliders would be negligible. Collective action by their colleagues would tend to hold them in line.

Q. What, exactly, would patients be told?

A. Each doctor would tell his individual patients something like this: "We do not propose to take part in socialized medicine because we cannot conscientiously become part of a scheme that would lead to the loss of all our liberties—yours and mine. We know from experience in other countries that Government-controlled schemes hurt the quality of medical care. We are not acting against you—the patient—our regular employer, but against a usurping, would-be employer—a political bureaucracy.

"I shall continue to serve you just as I have always done. I hope you will assist me in preserving freedom for America and quality medical care for its people. I urge you to write your Congressman and ask the immediate repeal of this unjust tax."

Q. How would payments by patients be arranged and (if necessary) enforced?

A. Most patients would continue to pay their doctors just as they do now. We do not believe this would constitute a problem.

Q. What assistance would be given to doctors who were hard-hit financially?

A. Universal non-participation would not change the doctors' present status, financial or otherwise. The vast majority of physicians would continue to serve their patients on a fee-for-service basis.

Q. What steps by Government

*Current officers: President, Lawerence Shinabery, M.D. Fort Wayne, Ind.; President-elect, Denton Kerr, M.D., Houston, Tex.; Secretary, F. B. Exner, M.D., Seattle, Wash.; Treasurer, C. H. Fredrickson, M.D., Missoula, Mont.; Speaker, House of Delegates, J. E. Hadley, M.D., Oil City, Pa.; Executive Secretary, Harry E. Northam, Chicago, Ill.

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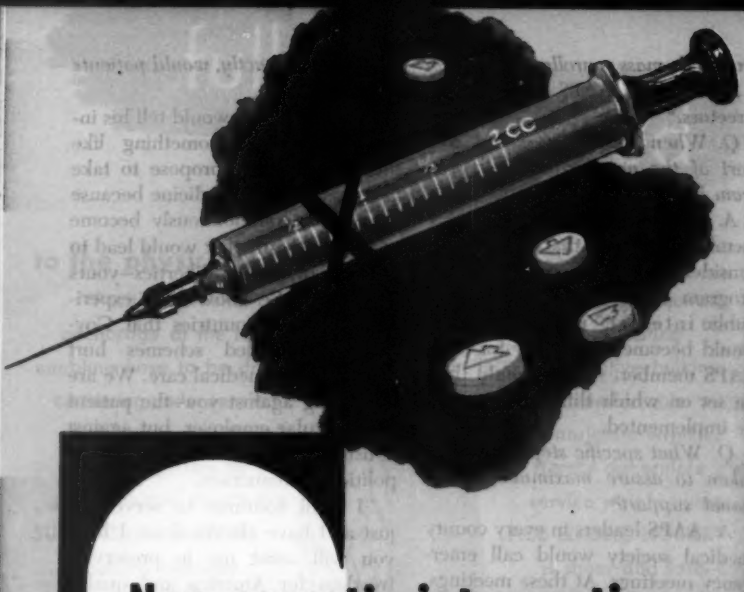

Non-narcotic intervention of pain

The use of an analgesic such as Anacin is being given increasing preference over narcotics for the relief of pain following minor surgery, trauma, or severe muscular aches. The advantage of the APC formula, as represented in Anacin Tablets, is a combination of fast relief and long lasting relief without the after effects attendant with the use of narcotics. Anacin also offers a distinct advantage over salicylate therapy because of the prolonged influence over pain symptoms. Anacin is mildly sedative as well as analgesic in effect. If you have never used Anacin in your practice and would care to give these tablets a trial, just write for samples on your letterhead.

ANACIN

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could be anticipated in its attempt to upset the non-participation program, and how could the doctors effectively resist?

A. There are *no* steps the Government could take, as long as the people are governed within the framework of the Constitution and of the Bill of Rights. All proposed legislation recognizes the doctors' Constitutional right not to participate.

Q. What specific results would this program bring?

A. It is difficult to predict the *exact* reactions of doctors and patients, since non-participation is an action contemplated for the future. But we believe it would break the back of any political medicine scheme. In British Columbia, socialized medicine is the law of the land; but it is inoperative because most physicians there decline to participate. Non-participation has also succeeded in the Union of South Africa and in the City of San Francisco (where, since June 1947, most doctors have declined to work for the city-operated Health Service System).

A harbinger of equally good results throughout the United States is the Sixth MEDICAL ECONOMICS Survey—which showed that 61 per cent of all private physicians favored non-participation and that 24 per cent were undecided. We are confident that a big majority of those in the 24-per-cent group would embrace non-participation if assured of colleagues' support. END

One-Man Town

● Folks in Union City, Okla., look on David P. Richardson as a jack of six trades, master of them all. Fact is, the 81-year-old M.D. has been the town's only banker, only physician, and only registered pharmacist for the last half century. And until recently, he was its postmaster (now his wife's job). He's also the lawyerless town's legal adviser, has been mayor "more times than I can recollect." One building [▲] houses his bank and drugstore [▼] plus post office and medical office. He's Oklahoma's oldest active doctor and has delivered more than 3,500 babies.

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White Laboratories, Inc., Pharmaceutical Manufacturers, Newark, 7, N. J.

Squabble Waxes Over Rx Refills

Why doctors, druggists, and the Government are locked in a three-way wrangle

• Physicians have been projected into the center of a many-sided fight over the prescription-refilling practices of druggists. The problem is to be aired on Capitol Hill during the new session of Congress, just opened. Medicine's viewpoint will be a big factor in determining the outcome.

The controversy boils down to this: How much control should the Federal Food and Drug Administration exercise over the refilling of prescriptions by pharmacists—particularly when the doctor has not given specific refill instructions?

Underlying this question are two others: What does the doctor have in mind when he writes an original Rx without any mention of refilling? Does he expect the patient to be able to get as many refills as he wants without coming back for a check-up?

Directly and deeply concerned, organized pharmacy is widely split on what steps to take. Naturally, pharmacists would prefer to see the Federal Government keep its hands off. But the FDA is bringing Federal court action against some druggists for "unauthorized refilling" of Rx's involving "dangerous" drugs. So pharmacy is faced with the problem of doing something.

New Prescription Methods?

The doctor has a big stake—both professional and economic—in how the dispute is finally settled. Whatever the upshot, the prescription-writing habits of many medical men are certain to undergo changes.

At its session last November, the AMA Council on Pharmacy and Chemistry listened to spokesmen for the various viewpoints in pharmacy. But the problem proved so complicated that the council had to postpone a decision. It dumped the matter into the lap of a three-man committee for further study.

Actually, the Rx-refill fight has been brewing for two years. The

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**Wallace Werble, author of this article, is the editor of F-D-C Reports, a weekly newsletter for the drug and related industries. He has been a Washington newsman for more than fifteen years.*

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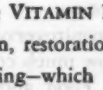

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Vitamin B_1 (Thiamine Hydrochloride)	3 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.3 mg.
Niacinamide	15 mg.
Calcium Pantothenate	1 mg.
Mixed Tocopherols (Equivalent to 3 mg. of Synthetic Alpha Tocopherol)	4 mg.

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FDA position was first explained to the medical profession by this magazine in the spring of 1949. Except for the mounting number of FDA court cases against pharmacists, the basic situation is roughly the same today as it was then. Here is how MEDICAL ECONOMICS described it in April 1949:

"It has long been customary for pharmacists in many areas to regard the absence of any reference to refill on a prescription order as the signal to refill the prescription as many times as the patient requests. Now the FDA wants pharmacists to regard the absence of refill instructions as a signal that the prescription is *not* to be refilled—unless the doctor provides additional instructions.

"The FDA view is that a pharmacist should not refill *any* prescription without the specific authorization of the physician. If the doctor wants a patient to have a prescription refilled, he must specifically say so—either on the face of the original order or in subsequent instructions to the pharmacist.

"Some physicians have been using variations of the Latin *Non Rep.* to indicate they do not want certain prescriptions refilled. The practice of indicating a specific number of refills also prevails in many localities. But, in the absence of such notations, many pharmacists have made it a practice to refill ad lib."

Today, the FDA says, the "unauthorized" refilling of prescriptions has led to serious and even fatal consequences, particularly where dangerous drugs are used. In some instances, it claims, ad lib refilling has enabled a patient to pass his favorite Rx around among every Tom, Dick, and Harry he knows. It is not even unusual, says the FDA, to find prescriptions being refilled long after the doctor who wrote them has retired or died.

No Court Test

So far, none of the "refill" court cases has been contested (though a test case may now be in the making). To date, the pharmacist-defendants have either pleaded guilty or *nolo contendere* (no contest) and been fined. A few have been placed on probation.

As is usually the case when an enforcement agency embarks on a new program, the first defendants were flagrant violators. They also were men who had broken a second FDA rule: They had sold certain "dangerous" drugs without any prescription whatsoever.

In these early "refill" cases, barbiturates were the only drugs involved. More recent cases—either already filed in court or still in the making—embrace a longer list of drugs, including Benzedrine, Dexedrine, the sulfas, antibiotics, hormones, and thyroid. Originally the FDA held that the ban on "unauthorized refilling" covered *all* prescriptions—regardless of the drugs prescribed. But it never initiated a

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case based on an admittedly harmless drug, such as a vitamin preparation.

In spite of the FDA enforcement program, doctors have not been quick to change their prescription-writing habits. And pharmacists who try to live up to the FDA ruling have often run into trouble. Particularly so where they compete with others who stick to traditional refilling practices.

When an Rx carries no refill instructions, the conscientious pharmacist may check with the doctor. But such repeated checking could become a nuisance and the doctor is apt to resent the intrusion. He may even regard the druggist as incompetent for apparently not knowing when to refill an Rx.

In some cases, real emergencies have developed: A refill is needed without delay, but the druggist is unable to contact the doctor.

Individual pharmacists, their associations, and some drug chains have made efforts to keep doctors informed about the new requirements. In some places, they have even run explanatory ads in newspapers.

Where Druggists Stand

What is organized pharmacy's stand on the issue? Here are the positions of its two major organizations:

The National Association of Retail Druggists (NARD) is pushing a bill in Congress that would modify the present law. It would let pharmacists refill prescriptions for certain drugs ad lib. But it would prohibit refilling prescriptions for other drugs without specific orders from the doctor.

Under this plan, the FDA would set the boundary between refillable and non-refillable prescriptions. After public hearings, it would be empowered to list those drugs that are so dangerous they should bear an "Rx legend" on the manufacturer's package. The proposed legend would read: "Caution: Federal law prohibits sale or dispensing without prescription."

To refill an Rx for such a drug, the pharmacist would have to get express permission from the doctor —either on the original prescription blank or by later order. Oral authorization would be permitted only if the doctor were willing to back the pharmacist in case of a check-up by Federal authorities. On all prescriptions for drugs where the manufacturer's package did *not* contain the "Rx legend," unlimited refills would be allowed.

The NARD bill is being sponsored on Capitol Hill by Senator Hubert Humphrey (D., Minn.) and by Representative Carl Durham (D., N.C.). Both men are themselves pharmacists. The bill was prepared after consultation with the FDA, which has since officially approved it. The NARD, representing 35,000 retail druggists, has in the past proved its ability to bring powerful pressure to bear on Congress. [*Turn page*]

Although the maker's nameplate is of no use whatsoever in the function of a diagnostic instrument, it is, nevertheless, extremely important to the prospective purchaser. In effect, it is the maker's way of saying that this instrument may be used as a gauge of his design and manufacturing ability. And, as with any signature, *the reputation behind the name determines the actual value of that to which the name is affixed.*

Many thousands of doctors, hospitals and clinics throughout the world have learned to respect the name "SANBORN" on diagnostic instruments. For they know from experience that their requirements are most completely fulfilled by apparatus bearing the SANBORN nameplate. They also recognize that a 33-year background has been so guided to give Sanborn Company leadership, not only in continually producing dependable precision instruments, but in developing many important "firsts" for the fields of cardiac and metabolism diagnosis.

Other manufacturers in like fields also show their recognition of Sanborn capabilities by following the Sanborn lead — to the extent, for example, that there is today a remarkable similarity in design and appearance between the Sanborn Viso-Cardiette and some of the "newer name" direct writing 'cardiographs.

Remember, the SANBORN nameplate is your only assurance that you are getting an electrocardiograph (or any of the other instruments made by Sanborn Company) that will surely meet all recognized standards. Once affixed to an instrument, the SANBORN nameplate becomes a signature to a guarantee of dependable and outstanding performance — a guarantee that is completely trustworthy though only "signed with a screwdriver."

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Manufacturers of: Viso-Cardiette • Instomatic Cardiette • Poly-Viso Cardiette • Twin-Viso Cardiette • Metabulator • Electromanometer • Electrophrenic Respirator • Ballistocardiograph

The American Pharmaceutical Association (APhA) has petitioned for a public hearing on the idea of a new administrative ruling *without* new legislation. The sought-for ruling would permit pharmacists to refill all prescriptions except (1) those marked *Non Rep.* by the prescribing doctor; and (2) those containing barbiturates or significant amounts of narcotics.

The APhA takes the position that present law does *not* support the FDA enforcement campaign. The NARD, on the other hand, apparently regards existing legislation as supporting the FDA—and would change it. While the NARD has been the spokesman on all commercial matters affecting druggists, the APhA is usually regarded as the major voice of the professional side of pharmacy.

The APhA petition was filed with Federal Security Administrator Oscar Ewing last August. He held an informal hearing on it in October. Then, two months later, he proposed a regulation that would permit ad lib refilling of Rx's for harmless drugs. This apparently was an effort to keep the issue off Capitol Hill. While the regulation would accomplish part of the Durham-Humphrey bill, the NARD plans to continue the fight for its bill. It prefers to settle the controversy by legislation rather than by regulation.

At the same time, Ewing denied the APHA's petition for a hearing o na much broader refill regulation. That meant the APHA had to decide whether to accept Ewing's ruling or to appeal it to the courts.

What about the pharmaceutical manufacturers? They stayed out of the controversy untl the NARD bill was proposed. But most of them now object strenuously to those parts of the bill that would give Government the power to decide in advance how their products should be sold—whether over the counter or by prescription only. They are expected to press for amendments.

AMA Support

Although the AMA council postponed its decision on the NARD bill, it had previously gone on record as supporting the FDA view on refills—at least in principle. Before the council met in November, its secretary, Dr. Robert Stormont, wrote the FDA as follows:

"It is the duty and responsibility of the physician to determine whether or not a patient requires additional medication beyond that specified in the original prescription. The physician, rather than the pharmacist, should determine whether or not refilling of a prescription is indicated or warranted. A change in the condition of the patient frequently necessitates a change in dosage or medication. The repeated and indiscriminate refilling of prescriptions without the knowledge or authorization of the physician is a practice which must be condemned."

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THE coronary vasodilator potency of khellin has been demonstrated in recent experimental and clinical investigations, which leave no doubt as to its effectiveness in the angina syndrome.

KHELLOYD, with its high degree of purity, provides assurance of maximum clinical response.

A New Drug—Dimethoxy methyl furano chromone, otherwise known as khellin (visammin), was isolated from the seed of Ammi visnaga as early as 1879, but its therapeutic importance has only recently been fully understood. Availability of the purified product, as presented in KHELLOYD, is a still more recent development.

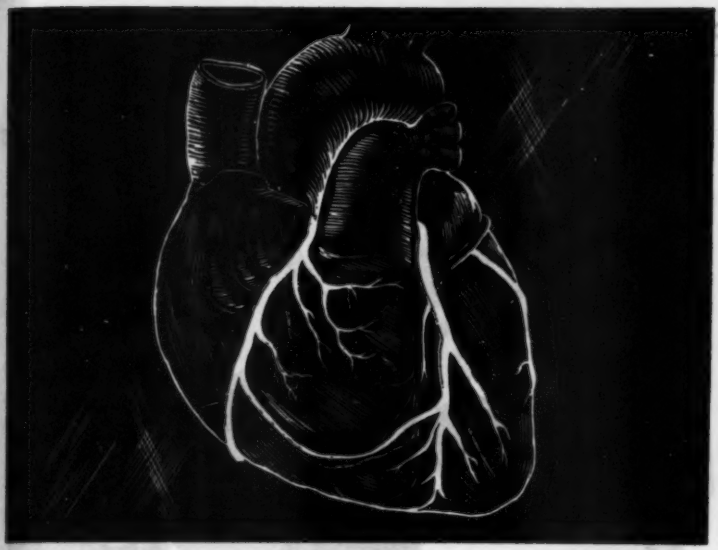
Pharmacologically Proved Action—KHELLOYD exerts a selective action on the coronary vessels to produce increased blood flow. It also relaxes the bronchial musculature by direct action. Both effects have been demonstrated in several species.

Clinically Effective—As a coronary vasodilator or, more precisely, as a coronary relaxant, khellin has been employed both prophylactically and therapeutically in angina pectoris. The results, as reported in the literature, indicate that under therapy with purified khellin exercise tolerance is increased, anginal attacks are reduced in frequency and lessened in severity, and in many instances there is an improvement in the electrocardiographic findings. Results in bronchial asthma are equally encouraging.

Clinically Safe—In the therapeutic dosage range, the toxicity of khellin appears to be low. Side-effects, when they occur, may consist of nausea, vomiting, vertigo, drowsiness and restlessness.

Indications: KHELLOYD is indicated as an aid in the prevention and treatment of angina pectoris attacks. It has also been found beneficial in relief of bronchial asthma.

Dosage: The usual adult dose is 1 tablet (50 mg.) 3 or 4 times daily after meals until favorable results



are obtained. Dosage should then be reduced to a maintenance level —1 to 3 tablets daily. The drug is cumulative and maintenance dosage should be adjusted for each case individually. During acute episodes, single doses as high as 200 mg. may be given.

KHELLOYD is supplied in bottles of 50, 250 and 1000 tablets, each containing 50 mg. of purified khellin (visammin).

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44 Types of Insurance: a Checklist

This inventory will help you to spot gaps quickly in your present coverage

● Ever considered embezzlement insurance? Or shrubbery coverage? Or animal liability?

It's a rare physician who has even heard of all three. Yet many little-known types of insurance have been devised to meet special needs. You'll find them nutshelled below, along with the better-known kinds.

By scanning the list, you can get a bird's-eye view of the completeness of your current insurance program. You may well find some types of coverage that you don't have and should.

ACCOUNTS RECEIVABLE
Compensation for accounts made uncollectible by destruction of records.

AIRCRAFT
Protection from liability for bodily injury and property damage; protection from hazards of crash, fire, land damage, marring, theft, and windstorm.

ANNUITY
Provides a lump sum or income as of a specified future date.

AUTOMOBILE
BROAD FORM: Auto liability policies cover you in your own car, and also during limited use of other persons' cars. If you frequently borrow cars, obtain a broad coverage policy. Similar protection is available if you frequently hire automobiles.

COLLISION: Covers damage to insured car by accidental collision or upset.

COMPREHENSIVE: Covers the insured car against fire, theft, flood, tornado, hailstorm, explosion, vandalism, and glass breakage.

EMPLOYER'S LIABILITY: Covers liability defined by law (except workmen's compensation laws) for bodily injury, including death therefrom, sustained by an employe who was engaged in the operation or maintenance of the insured's automobile.

FIRE AND THEFT: Covers insured automobile.

INJURY LIABILITY: Covers liability for bodily injury or death of passengers and pedestrians resulting from accident. [*Turn page*]

**This checklist was prepared by W. Clifford Klenk, New York City insurance consultant.*

What's What With Your Insurance

• Your long-range plans should include a review of your insurance program every five years, but here are some basic necessities to have within arm's reach at all times.

✓ A list of all your insurance policies, showing company, type of coverage, face amount, premium.

✓ A record of what your life insurance would provide if anything happened to you—*e.g.*, how much income your family would have, and for how long; "clean-up" fund it would get in cash at your death; amounts set aside for emergencies and for special things like a son's college education.

✓ Evidence that what your insurance provides will actually meet your family's needs. A detailed list of those needs is of course a "must."

✓ A notation of the income you can expect from your insurance at retirement.

✓ A record of the total current cash value of all life policies.

✓ The facts on whether your life insurance proceeds would be free from attachment by, say, your wife's creditors; whether such policies contain "common disaster" clauses; whether premiums would be waived if you became disabled.

✓ Written information for your wife: location of your policies, whom to call on for advice in arranging settlements and benefits, etc.

MEDICAL EXPENSE: Pays medical, surgical, ambulance, hospital, nursing, and funeral expenses for any passenger injured while entering, leaving, or traveling in insured's car.

PROPERTY DAMAGE: Covers liability for damage to property of others.

BUILDING, FIRE
Covers loss by fire or lightning.

BURGLARY
(See Personal Property.)

DISABILITY
Pays the holder (for life or to age 65) if he is unable, by reason of disability, to continue to earn a living. It is available, in combination with life insurance, from relatively few companies.

EMBEZZLEMENT
(See Fidelity.)

EMPLOYER'S LIABILITY
(See Automobile and Liability.)

EQUIPMENT
Covers practically all risks of loss or damage.

EXPLOSION
(See Extended Coverage and Residence Blanket Policy.)

EXTENDED COVERAGE
This endorsement, added to a fire insurance policy on building or contents, provides coverage against damage by windstorm, hail, riot, aircraft, vehicles, smoke from heating unit, or explosion (except of steamboiler). It costs less than individual policies giving the same protection.

EXTRA EXPENSE
Covers expenses for moving to new quarters when fire or lightning has made your own premises uninhabitable.

FIDELITY
Covers loss of money, securities, or other property because of an employe's dishonesty.

FIRE
(See Automobile, Building, Equipment, Furniture, and Personal Property.)

FORGERY
Protects against loss by forgery or alteration of checks or drafts whether issued or accepted.

FURNITURE
Covers direct loss due to fire or lightning. (See also Extended Coverage.)

FUR FLOATER
Insures furs against most risks.

HAILSTORM
(See Extended Coverage.)

HEALTH AND ACCIDENT
Medical society and commercial policies.

HOSPITALIZATION
Blue Cross and commercial policies.

HOUSEHOLD EFFECTS
Covers direct loss by fire or lightning. (See also Extended Coverage.)

HURRICANE
(See Extended Coverage.)

INSTRUMENTS
(See Equipment.)

JEWELRY FLOATER
Insures jewelry against all risks.

LANDSCAPING
Protection against damage to trees, shrubbery, lawn furniture, and decorations may be purchased as an

when "eating for two" ...plenty of citrus fruits

Most obstetricians today insist that their mothers ingest plenty of vitamin C, particularly after the first trimester[1] (8 oz. citrus juice during pregnancy, 12 oz. while lactating).[2] Pregnancy is thus made safer because toxemia is thereby reduced.[7] Also, more babies are born normally and with a higher birth weight, while premature and still births are fewer.[3,4] In addition, both maternal and infant health is improved postpartum when an adequate vitamin C regimen has been followed throughout pregnancy.[3] Most mothers enjoy the flavor of fresh Florida citrus fruits (so rich in vitamin C and containing other nutrients*), as well as the energy pick-up provided by their easily assimilable fruit sugars.[5]

* * *

**Citrus fruits—among the richest known sources of vitamin C—also contain vitamins A and B, readily assimilable natural fruit sugars, and other factors, such as iron, calcium, citrates and citric acid.*

FLORIDA CITRUS COMMISSION
LAKELAND, FLORIDA

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endorsement on building fire insurance policies.

LIABILITY (OWNER'S OR TENANT'S)

ANIMAL: Covers claims for injuries inflicted by assured's horse or other animal off his premises.

COMPREHENSIVE: Gives broader protection at relatively lower cost against the combined hazards listed here under Liability. In addition, it covers (1) medical bills of guests injured on assured's premises and (2) claims for injuries sustained by any person, except an employe, by an act or activity of the assured, his spouse, and his children, in or *away from* his residence. These two protections are not available under separate policies.

EMPLOYER'S: Covers claims for employes' injuries sustained in performance of their duties.

PROPERTY DAMAGE: Covers accidental damage to, or destruction of, property.

PUBLIC: Covers claims for injuries sustained in or about the residence by anyone except an employe.

SPORTS: Gives protection against liability while participating in any sport.

LIFE

ENDOWMENT: Pays a definite sum to the policyholder after a specified number of years if he is then living. If the policyholder dies before maturity of the endowment, payment is made to a beneficiary.

GROUP: Issued without medical examination to a group of employes under a master policy.

LIMITED-PAYMENT: Covers full span of life but premiums are paid only for a specified number of years.

ORDINARY: Issued usually in amounts of $1,000 or more with premiums payable on an annual, semi-annual, quarterly, or monthly basis.

TERM: Covers a specified number of years, but may be renewable in some forms.

MALPRACTICE

The familiar financial protection against claims arising from professional work.

MOVING

Covers property during transportation from one location to another.

PERSONAL EFFECTS

Covers effects only during travel. (See also Personal Property.)

PERSONAL LIABILITY

(See Liability.)

PERSONAL PROPERTY

A broad, moderately expensive policy which insures against most risks to the personal property of as-

BOTH toughness AND softness ARE ESSENTIAL IN CONSTIPATION MANAGEMENT

In KONDREMUL, each micro-globule is coated with a tough film of chondrus which resists gastrointestinal enzymic action—yet KONDREMUL pours freely from the bottle, is of velvety softness.

KONDREMUL, being finely subdivided, contributes soft bulk to the dry fecal residue, easing elimination and encouraging regular bowel habits.

N.N.R.
- **KONDREMUL** Plain (containing 55% mineral oil).
- **KONDREMUL** with non-bitter Extract of Cascara (4.42 Gm. per 100 cc.)
- **KONDREMUL** with Phenolphthalein—.13 Gm. (2.2 grs.) per tablespoonful.

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Also in tablet form KONDRETABS

—the original Irish Moss—Methyl Cellulose Bulk Laxative in Tablet Form.

KONDRETABS induce soft, easily eliminated bulk—no bloating, griping, impaction. Convenient, pleasant, easy to take.

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sured, members of his family, his guests, and his servants while in residence, at any point in the world, or in transit.

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Indemnifies for destruction of plate and all other fixed glass.

PROPERTY DAMAGE
(See Automobile and Liability.)

PUBLIC LIABILITY
(See Automobile and Liability.)

RADIUM
Covers practically all risks of loss or damage.

RENTAL VALUE
Pays your rent while your own premises are uninhabitable as a result of fire or other damage. May be added to fire policy or extended coverage endorsement.

RESIDENCE BLANKET POLICY
Covers theft in or out of residence; comprehensive personal liability; water damage (from roof or plumbing leaks, rain, hail, or snow, etc.); explosion (*e.g.*, of oil burner); loss of use of residence as result of foregoing; repair or replacement of systems of heating, plumbing, lighting, refrigeration, or cooking accidentally damaged; glass breakage; property damage caused by airplanes or land vehicles.

SMOKE, SMUDGE
(See Extended Coverage.)

THEFT
(See Automobile, Equipment, etc.)

VANDALISM
May be added to fire insurance policies or to extended coverage endorsement.

WINDSTORM
(See Extended Coverage.)

WORKMEN'S COMPENSATION
(See Liability.)

—W. CLIFFORD KLENK

Shot in the Head

● The patient, whom I'd never seen before, arrived at my office pale and breathless. Collapsing into a chair, she managed to open her handbag. "Quick—here's the ampule!" she gasped.

It was adrenalin hydrochloride, and I injected it pronto. She got up and began to thank me. In mid-sentence she dropped to the floor, out cold. I hoisted her back into the chair, now panicky myself. I'd opened the office only three days before. Was one of my first patients to die there?

Luckily, in a few moments, she was conscious again. With gushing gratitude, she pressed two crisp dollar bills into my hand.

"They told me I'm allergic to it," she said, "and I keel over every time I take it. But I feel *so* much better afterwards."

—M.D., MISSOURI

What the AMA Delegates Did

Here's a quick guide to organized medicine's new plans for 1951

● Of the 195 AMA delegates who convened in Cleveland last month, a good many were flushed with political victory. But not for long. Louis B. Seltzer, editor of the Cleveland Press, cooled them off in a banquet speech the very first night.

Taking note of the doctors' newfound power at the polls, Mr. Seltzer handed them a blunt warning: "The medical profession must provide *positive* solutions to *all* the problems that now confront it—or be branded as just another pressure group."

As if in response, the delegates spent the next three days developing affirmative plans. At least that was their self-prescribed regimen. If they deviated now and then, it was only to deliver a few final thrusts at the Ewing coterie—such as Dr. Elmer Henderson's comment that "any compulsory health insurance bill in Congress today would go down to defeat by at least a 2-to-1 vote."

Most of the time, though, the House of Delegates bore down on what Clem Whitaker called "undone jobs and unsolved problems." Plenty of them had accumulated during the past two years. At Cleveland, medicine's policy-makers did what they could to whittle down the pile.

Topmost items in the stack—the financial plight of the medical schools, the lack of rapport with organized labor—were handled with headline-worthy flourishes.* But many less publicized actions may prove just as significant to the doctors back home. For at their midwinter session the AMA delegates:

¶ Urged that much more money be spent on the association's positive programs. The Board of Trustees promptly announced stepped-up 1951 budgets totaling $850,000 for the AMA groups working in the realm of medical service, medical economics, public relations, rural medicine, legislative relations, and such. (This compares with $706,000 earmarked for strictly scientific activities.)

¶ Directed a special budget boost for the Council on Medical Service, entrusted with much of the AMA's affirmative work. Delegates asked that the council get suffi-

*See pages 60 and 63, this issue.

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Full tilt-table convenience, of course! *Two-tube operation* for alternating between radiography and fluoroscopy without loss of time or extra effort. Double focus 100 MA tube for sharp, clear detail at all MA settings...and longer tube life, too. Completely automatic push-button technique selection. Ultra compact design. Write for complete information to PROFESSIONAL EQUIPMENT COMPANY, Dept. ME 1, P. O. Box 488, Maywood, Ill.

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cient staff and money to conduct more field surveys, to ferret out local medical care gaps, and to help rural areas get physicians. (Until recently, Dr. Herbert P. Ramsey pointed out, the council "didn't even have enough personnel to analyze all the data it collected.")

¶ Noted that collection of the $25 AMA dues was coming along well enough to finance these new activities, despite wide variation from state to state (94 per cent have paid in Pennsylvania, less than 40 per cent in some rural states). Privately, it was estimated the AMA might lose upwards of 25,000 members next month, when delinquents are dropped from the rolls.

¶ Approved a new study of the AMA Public Relations Department, with a view to getting it in better shape for the long pull. The study will be directed by Drs. Gunnar Gundersen, Edwin S. Hamilton, and B. R. Kirklin.

¶ Cast a worried look at the civil medical defense lag and urged communities to speed up mutual assistance plans. The house warned that "physicians will be in the majority among the casualties in the event of a wartime attack on any of our cities . . . necessary medical care must then be furnished by physicians from other areas."

¶ Called for a major expansion of the country's blood bank system. Resolved the delegates: "The time for talk is past. The blood procurement problem will soon strain the facilities of all existing banks. We need to expand existing blood banks and start new ones." The Red Cross can't do the job alone, it was emphasized; its thirty-four regional centers issue less than 15 per cent of all the whole blood now being used.

¶ Decided that medical manpower in the armed forces was being conserved better than in the old days, when the military was "reckless in the call-up of physicians and wasteful in their use." Delegates traced the improvement to civilian physicians in the Defense Department—*e.g.*, Dr. Richard L. Meiling—and to newly-appointed advisory committees. They turned down a proposal that "flying squadrons" be organized to inspect all military hospitals, here and abroad, for medical waste. Ruled the delegates: "unnecessary."

Ethics Quandary

¶ Suggested that one section be deleted from the Principles of Medical Ethics—the part that says "an ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients . . ." Small-town physicians had complained that this proviso seemed to outlaw activities in which they must necessarily engage. The AMA Judicial Council has taken the point under advisement.

¶ Asked that "all encouragement possible" be given to the "Junior AMA"—the medical students' asso-

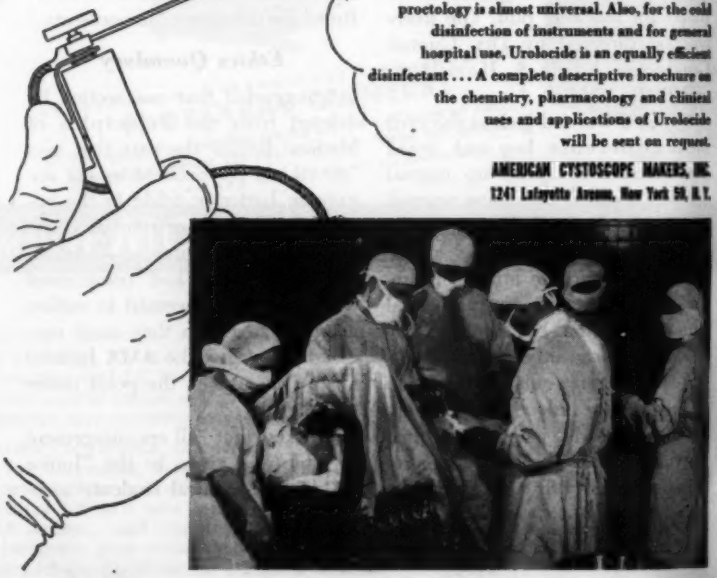
UROLOCIDE

a new, powerful bactericide . . .

Available in pure crystal form in packages of 3.8 Gm. sufficient to make 1 gallon of 1:1000 solution or tincture; also:

Tincture 1:500
Tincture 1:1000
Aqueous Solution..1:1000
} 8 oz. and 1 gal. bottles

Urolocide—a new non-toxic quaternary ammonium compound of unprecedented bactericidal efficiency—marks an important step forward towards the realisation of the surgeon's dream of optimum antisepsis . . . Urolocide is an all-purpose disinfectant containing no phenolic, mercuric or other corrosive ingredient, yet it is rapidly bactericidal and fungicidal—in highest dilutions—against a wide range of commonly occurring pathogens (both gram-positive and gram-negative). Urolocide possesses extraordinary detergent and penetrating properties and is non-irritating to human tissues. It is odorless, colorless, non-staining and water-soluble . . . Urolocide's range of usefulness in major and minor surgery, obstetrics, gynecology, genito-urinary infections, dermatology and proctology is almost universal. Also, for the cold disinfection of instruments and for general hospital use, Urolocide is an equally efficient disinfectant . . . A complete descriptive brochure on the chemistry, pharmacology and clinical uses and applications of Urolocide will be sent on request.



AMERICAN CYSTOSCOPE MAKERS, INC.
1241 Lafayette Avenue, New York 59, N. Y.

ciation now being organized under the direction of Leo Brown, former PR man for the Pennsylvania State Medical Society.

¶ Renewed their plea for an independent health agency in the U.S. Government, to control all Federal medical activities except the military. Delegates would prefer a Department of Health, headed by a Cabinet-rank physician; but they decided this long-standing goal was "unattainable at this time."

¶ Hailed the "substantial expansion" of the AMA Washington office and gave it credit for equally substantial achievements: "Several bills favored by the AMA have been enacted into law during the year; not a single bill opposed by the association has been enacted."

¶ Hinted that medical society grievance committees ought to crack down harder on fee-happy practitioners. Said Dr. Louis H. Bauer: "We must be absolutely relentless in disciplining members of our profession who think of themselves first, the public second."

¶ Concluded they'd got their money's worth out of the AMA fall advertising campaign. Delegates learned that the 65,246 advertisers who bought tie-in space ran a surprising range—from dairies, dress shops, music stores, and beauty salons to auto dealers, lumber yards, movie theaters, and labor groups. Said Dr. Elmer Henderson: "These new-won friends of our profession spent more than $2 million in a two-week period, or nearly twice as much as the AMA itself, in support of medical freedom."

¶ Vetoed a Tennessee resolution that sought to get non-service-connected cases out of V.A. hospitals, moving the low-income ones into civilian hospitals under Government health insurance. Delegates were all for a tighter policy on V.A. hospitalization, but they decided the Government health insurance idea might set a "dangerous pattern."

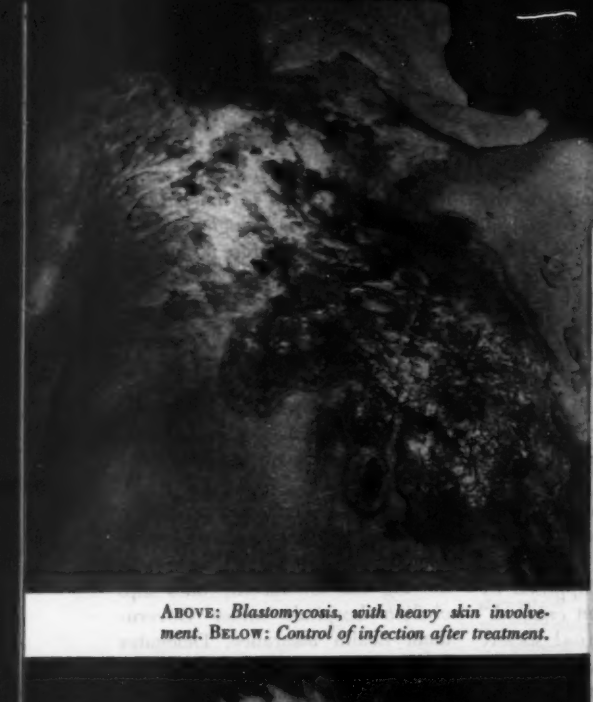
¶ Named Dr. Dean Sherwood Luce, 74, "G.P. of the Year." Dr. Luce has practiced in Canton, Mass. ever since 1905, was out on a house call when informed of the award. His kind of medicine, the delegates noted, "includes not only the skillful care and treatment of neighbors, but also the ability to love and be loved." Dr. Luce has delivered three generations in several families. "When I get to the fourth generation," he told the AMA cheerfully, "I'll retire." END

* HANDITIP *

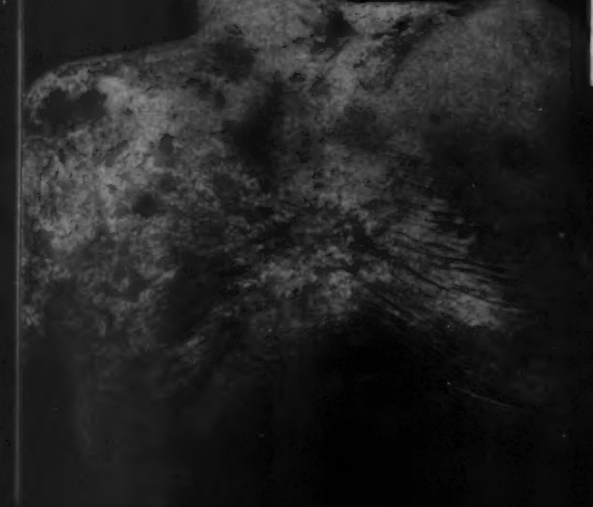
Fee Feat

When stumped in setting a fee, I usually leave it up to the patient. Often he names a higher figure than I would have. More important, I've never yet failed to collect a fee set by a patient. —M.D., IOWA

* * * * *



ABOVE: *Blastomycosis, with heavy skin involvement.* BELOW: *Control of infection after treatment.*



Two Kodak Vari-S... Standlights are arrang... indicated above. Ligh... at camera level; light ... 24" higher than the ca...

BLASTOMYCES DERMA...
A—*Budding cells in ... (Photomicrograph.) ... Giant colony in Sabouraud ... agar. C—Growth of two ... cultures on two different ... dia at room and body ... peratures.*

Serving med... progress t...

Picture the patient

. . . from initial diagnosis to final discharge

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Thus, documentation is complete . . . with adequate material available in all significant cases for records, instruction, publication.

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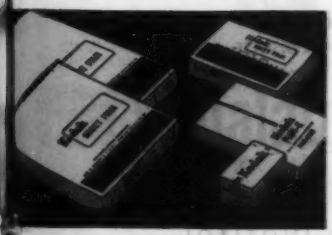

X-ray films, screens, and chemicals; electrocardiographic papers and film; cameras and projectors—still- and motion-picture; enlargers and printers; photographic film—full-color and black-and-white (including infrared); photographic papers; photographic processing chemicals; microfilming equipment and microfilm.

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REFERENCES: 1. Dry, T. J. et al.: Proc. Staff Meetings Mayo Clin., 21:497, 1946. 2. Hoagland, R. J.: Am. J. Med., 9:272, 1950. 3. Smith, R. T.: J. Lancet, 70:192, 1950.

FORMULA: Each enteric-coated tablet or each teaspoonful of chocolate-flavored liquid contains 0.3 Gm. (5 gr.) sodium salicylate U.S.P., and 0.3 Gm. (5 gr.) para-aminobenzoic acid (as the sodium salt).

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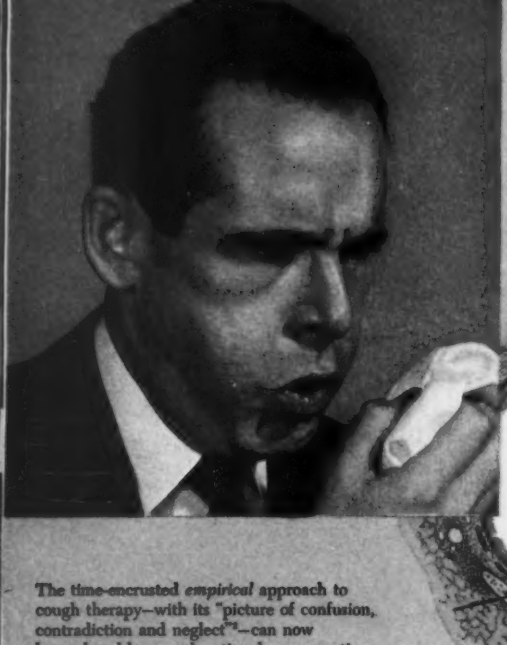

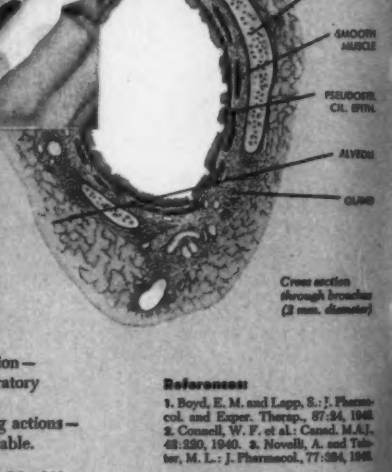

Cross section through bronchus (3 mm. diameter)

The time-encrusted *empirical* approach to cough therapy—with its "picture of confusion, contradiction and neglect"[2]—can now be replaced by sound, *rational* non-narcotic treatment, thanks to the pioneering studies of Boyd et al.,[1,2] demonstrating that glyceryl guaiacolate is the most powerful of expectorants commonly used. Robitussin—the antitussive-expectorant with specific drug action—provides glyceryl guaiacolate for increasing respiratory tract fluid, together with desoxyephedrine, for its bronchial-spasm-relieving[2] and its mood-improving actions—in an aromatic syrup that is highly patient-acceptable.

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References:

1. Boyd, E. M. and Lapp, S.: J. Pharmacol. and Exper. Therap., 67:94, 1940. 2. Connell, W. F. et al.: Canad. M.A.J., 43:230, 1940. 3. Novelli, A. and Taylor, M. L.: J. Pharmacol., 77:294, 1943.

Formula:

Each 5 cc. (1 teaspoonful) contains 100 mg. glyceryl guaiacolate and 1 mg. desoxyephedrine hydrochloride, in a palatable aromatic syrup.

Robitussin®

Robins

promotes useful cough... minimizes harmful cough

'You Can't Practice There!'

Before you sue a former partner for violating an agreement not to practice nearby, just be sure the agreement is reasonable

● When Harry Turner, fresh from interne training, joined forces with Dr. George Brooks, it seemed like the beginning of a long and fruitful association.

To the elderly doctor, the young man was a godsend. He was competent, quick to learn, and patients liked him from the start. In time, the practice would be his and Dr. Brooks could retire.

But a year later, things were less rosy. The two men disagreed over their partnership contract. Feelings grew more and more strained. Eventually, Dr. Turner left and set up a practice of his own in the next town. With him went many of the old doctor's patients.

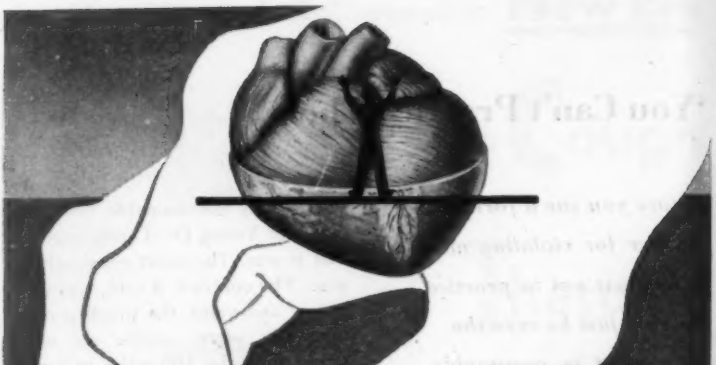
After due warning, Dr. Brooks filed suit. He charged his former assistant with violating the terms of their original contract, by which Dr. Turner had agreed, if they parted company, not to practice within a radius of 100 miles.

Was this unreasonable restraint of trade? Young Dr. Turner argued that it was. The court ruled otherwise. The contract, it said, was voluntary and valid; the practice of a physician often covers an area larger than the 100 miles in question. Harry Turner was forced to move.

No court will deny the right of a doctor to practice where he pleases. Yet any doctor can legally restrict his own right to practice by a contract with another physician. To stand up in court, the contract need merely be reasonable and not contrary to public policy.

Such contracts between doctors are fairly common. The motive behind them is clear. No physician in his right mind wants to train a potential rival. When he takes on an assistant, he entrusts the new man with intimate details of his practice. He gives him the benefit of his hard-earned knowledge and skill. He provides him with patients. Small wonder that he wants to protect himself.

With a reasonably-worded agreement to restrain the other doctor from competing with him, he can generally feel safe. If the assistant pulls out and opens an office within the forbidden zone, he has deliber-



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HIGHER *SALICYLATE LEVELS*

VITAMIN C PROTECTION

Pabasyl Tablets represent a new concept in antirheumatic therapy with the salicylates. Each enteric-coated tablet supplies:

Para-Aminobenzoic Acid*	0.3 Gm. (5 grains)
Sodium Salicylate	0.3 Gm. (5 grains)
Ascorbic Acid	0.01 Gm. (10 mg.)

Pabasyl Tablets afford rapid relief of pain, fever and inflammation in many rheumatic diseases because they provide:

1. **HIGHER Salicylate Levels** — With simultaneous administration, Paba and salicylates have a reciprocal action that increases salicylate concentration in the blood.

2. **LOWER Salicylate Dosage** — Paba not only boosts the salicylate level attainable with a given salicylate dose but also in itself contributes analgesic and antipyretic actions.

3. **Vitamin C Protection** — Ascorbic acid maintains Vitamin C levels often depleted by fever and salicylate therapy.

Enteric coating allays gastric irritation.

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In Bottles of 100 Tablets.

Dosage adult: 2 tablets three times a day.

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ately violated their pact and the courts will support the injured ex-partner.

Sometimes, though, there are fine distinctions. For example: What if the departing physician sets up outside the prohibited area but gets two or three patients living inside it? Must he give them up?

An Ohio doctor found himself up against this very poser. His contract prevented him from establishing himself within five miles of his former location. His new office was well outside that range. But occasionally he was asked to make calls in the forbidden territory. The court held that to restrain him from entering the area for such cases would be unreasonable. Issuance of an injunction against him was refused.

Failure to define distances precisely may also cause trouble. In a recent Pennsylvania case the limit had been set at fifteen miles. The doctor opened his office twelve miles away, airline distance. But the court interpreted "within a radius of fifteen miles" to mean fifteen miles by the shortest road—not by air. Figured this way, it was a little more than fifteen miles from the old to the new office. So the suit was dismissed.

Is the public harmed by these contracts between doctors? Most courts take a lenient view. In a Texas case, for instance, the judge said, "The public will not be hurt by such an agreement since every other physician and surgeon of equal competency is at liberty to practice the same profession within the same limited territory."

Usually, it's the defending physician who poses the public-interest question. In a Kentucky case where this happened the court held that there were ample physicians in the community for the citizens' medical needs. No monopoly, it asserted, would result from upholding the contract.

Rarely is restraint of trade itself a question. Most courts ask simply: Is this restrictive covenant reasonably necessary to preserve the goodwill or interests of the party in whose favor it is drawn? The answer, in most cases, is yes. But, it's worth a double check.

—ANDREW A. SANDOR, M.D., LL.B.

Welcome, Stranger

• The young man's trouble was apparently acute laryngitis. He stood hesitantly in the reception-room doorway, eying the nurse. "Is the doctor in?" he finally managed, in a hoarse whisper.

He wasn't exactly set at ease when the nurse whispered back, "No—come on in!"

—A. J. GLOSS, M.D.

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Editorial, Brit. M. J. 2:962, 1947

'ESKACILLIN 100', containing 100,000 units of penicillin per teaspoonful (5 cc.), and 'ESKACILLIN 50', containing 50,000 units of penicillin per teaspoonful—are the ideal penicillin preparations for infants and children because they can be given by mouth . . . and are so pleasant-tasting.

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Bronchitis	**Cellulitis**
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Otitis media	**Certain skin infections**

Eskacillin 100
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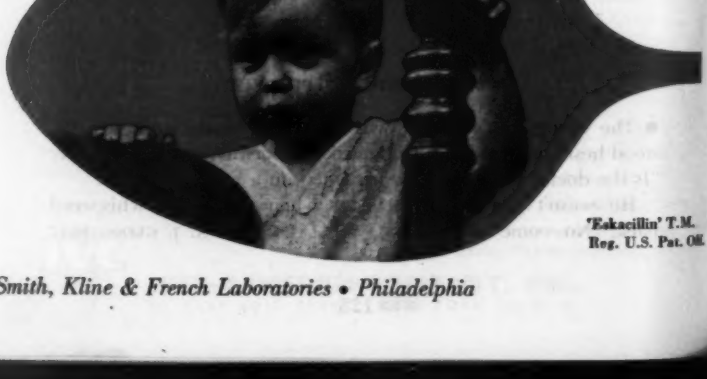
the unusually palatable liquid penicillins for oral use



'Eskacillin' T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories • Philadelphia

Is the Medical Corps Still Snafu?

Here's what one man found when he took a sampling of expert medical opinion

● Many a physician came out of the Army or Navy in 1945 with a vow that he would never again don a uniform. He still hadn't cooled off a year later when the AMA asked all ex-medical officers to air their gripes. As a result, the association got an earful: too much paper work, too many physicians assigned to wrong specialties, too much sitting around, too rigid tables of organization, uneven promotions, low salaries, unfair procurement methods.

To what extent have these defects been corrected?

The answer is important to all physicians these days—both those ticketed for military service and those due to shoulder heavier patient loads at home. To get some idea of how things stand, this writer queried a number of nationally known physicians who know the score on military medicine. The following comments reflect their collective views.

Paper work, red tape, and nonmedical functions are still favorite whipping-boys when medical officers get together. Yet many men agree that the services have made great progress in trimming away the doctor's nonprofessional tasks. In fact, some shrewd observers think the Army and Navy may be veering to the opposite extreme. The services now place so much administrative authority in the hands of non-physicians that lay officers may sometimes exercise very real control over medical activities. For instance:

Laymen in Command

Early in World War II, all Army hospital registrars were physicians. When doctors protested assignment to this largely administrative post, the Army handed the task to Medical Service Corps personnel. Now, a registrar has to tell the ward officer whether his diagnostic terminology is in accord with regulations. Nomenclature has to be standard—otherwise Army health statistics would be meaningless. Yet when a nonmedical registrar tells a physician what terminology to use, the M.D. begins a slow burn.

Quite a few doctors seem to believe that the Department of Defense has gone far enough in its efforts to relieve medical officers of administrative chores. Physicians

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PROVED: Records of 8 leading hospitals, where these tests were conducted for more than 10,000 cumulative baby days, show that care with Johnson's Baby Lotion reduced the incidence of skin irritation to an average of less than 2%.

(Records of a study, using *other* commonly accepted methods of skin care show incidence of skin irritation ranging as high as 55%.)

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12 distribution samples of new Johnson's Baby Lotion. Mail this coupon.

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Offer limited to medical profession in U.S.A.

re-entering the Army and Navy report that paper work and administrative mumbo-jumbo have been appreciably cut back—so much so that few medical officers now complain of being strangled in red tape.

Some flexibility has been introduced into tables of organization, but not much. Each fixed and mobile hospital of an Army division still has its quota of personnel, ambulances, and supplies. This means that the rank of each medical officer is fixed by his assignment in the hospital hierarchy.

Too Many Colonels?

Proponents of this system argue that it's the only feasible way of organizing medical service for troops. If each medical officer were individually evaluated according to his age, experience, and civilian training, they say our Medical Corps would be top-heavy with Colonels and Generals.

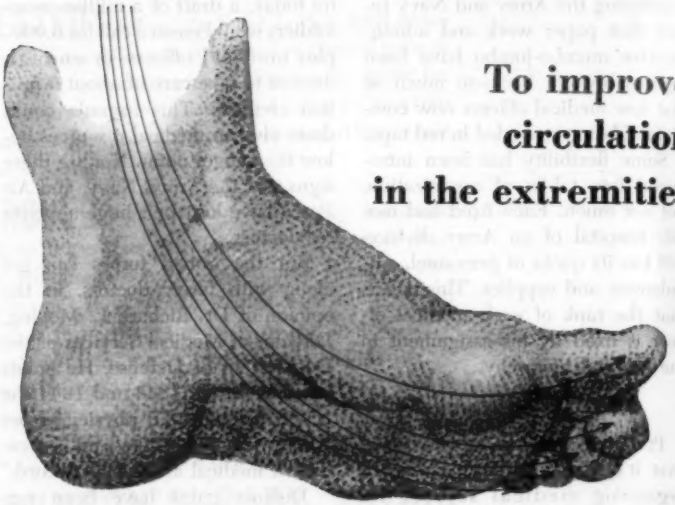
Opponents of the system counter that in these days of fast transportation, mobile medical teams could be set up without regard to tables of organization. And the military does make some concessions to this point of view. Each field Army, for example, has surgical teams directly under the control of the Army surgeon, available for dispatch to any point where needed. But on the whole, the T/O system hasn't changed with the times.

In 1945 there were more than six physicians in uniform for every thousand troops. Applying this ratio today, a draft of a million more soldiers would mean a call for 6,000-plus medical officers—or enough doctors to take care of about 6 million civilians. This formula could drain civilian medical resources below the danger point. Nor are there signs that the Army, Navy, and Air Force have lost their huge appetite for doctors.

But the armed forces *can* get along with fewer doctors, in the opinion of Dr. Richard L. Meiling, Director of Medical Services of the Department of Defense. He points out that during 1943 and 1944 the Navy had only 3.5 physicians per 1,000 men, yet chalked up "an excellent medical and health record."

Distinct gains have been registered in Army-Navy-Air Force medical unification. Army, Navy, and Air Force hospital records are beginning to resemble each other. Soldiers are received in Air Force and Navy hospitals, sailors in Army and Air Force hospitals, fliers in Army and Navy hospitals, without too much administrative difficulty. Medical officers are being exchanged between the services. A beginning has been made in the integrated purchasing of medical supplies. All this means stepped-up efficiency—which is good news for medical officers and those about to be.

Little is heard these days about assigning pediatricians to refract eyes, or about converting dermatologists into psychiatrists by military order. All evidence points to a scrupulous effort to use medical of-



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2/10350

ficers in their own specialties. Outstanding examples of bald misassignment are now difficult to find.

The procurement problem is still a trouble-maker and probably always will be. Those who denounce the recall of reservists and the drafting of physicians have offered no alternate solutions. A while back, when many doctors argued that the best method of procurement would be through the medical societies, the Army acceded. It began to use the medical societies as guides and advisers. At once, other doctors complained that their associations had no business functioning as "recruiting agencies." You can't please everybody—especially those M.D.'s who are "procured."

Free Care for Civilians

What about the Army's continued willingness to treat the dependents of soldiers? A good many medical men resent it, since there would obviously be need for fewer medical officers if the Army stopped treating civilians. But the Department of Defense retorts with a double-barreled answer: (1) Congress has authorized the care of dependents under certain conditions; (2) In the more isolated parts of the country—where many camps are located—civilian medical manpower could never take care of the huge influx of military dependents. And there the matter stands.

Impartial observers believe there are still bugs in the military medi-

cal service, but that the situation is better than during World War II. They think it's a good thing that the top medical man in the Department of Defense, Dr. Meiling, has a civilian's point of view. Here's what they feel is a fair over-all summary:

In the Medical Corps today, there's less of the prolonged idleness that frustrated so many medical officers during World War II. There's also less paper work for M.D.'s and there are fewer non-medical assignments. Pay is still low, yet—grade for grade—medical officers get the highest salaries in the armed services.

Tables of organization continue to be too rigid, although some improvements have been made. The greatest remaining weakness is probably in the lack of correlation between military and civilian needs. That's a problem doctors may have to toss in the lap of some higher authority. —JOSEPH ROBINSON, M.D.

Assurance...

often seems an unattainable feminine goal at some point in every woman's life because of vaginal infection.

At such times, the assurance which an *ethically recommended* douche powder such as TYREE's Antiseptic Powder confers, enhances therapeutic effectiveness.

For routine hygiene, TYREE's Antiseptic Powder brings cooling, soothing comfort. Its detergent action cleans thoroughly. Its low pH helps restore and maintain the normal acid pH of the vagina.

In most common vaginal infections this powerful but gentle antiseptic easily overcomes the pathogenic invaders. At the same time, its astringent properties help combat excessive flow and act as an effective deodorant.

For your next patient who needs effective, non-irritating therapy, prescribe TYREE's Antiseptic Powder.

Write today for a free professional sample.

FORMULA:
MENTHOL
THYMOL
EUCALYPTOL
PHENOL
BORIC ACID
SALICYLIC ACID
ZINC SULFATE (Dry)

TYREE'S ANTISEPTIC POWDER

In bottles of 2 ozs. 4 ozs. 8 ozs.

J. S. TYREE, CHEMIST, INC.

15th and H Streets, N. E., Washington, D. C.

Makers of CYSTODYNE, a Urinary Antiseptic

The Way to Buy a Dictating Machine

What to look for, what questions to ask, depend on how you intend to use it

• When choosing a dictating machine, it's little help to "ask the man who owns one"—that is, unless your needs closely parallel his. The important thing is how *you* will use it—whether for letters only or for other things too (*e.g.*, for dictating quick capsules of your patients' case histories, or for recording phone conversations).

Whatever your purpose, each type of dictating machine—tape, disc, belt, or wire—has something to offer. To decide among them, first ask yourself the following questions:

Should you economize by getting a single machine for both dictation and transcription? This will cut your expense nearly in half. Trouble is, your secretary can't transcribe while you're dictating—and vice versa. So, unless you confine your dictation to certain times of day, you'll probably want a dictating machine for yourself and a transcribing machine for her. You can then dash off letters whenever you wish, without creating a bottleneck. [*Turn page*]

Tape recordings on machines like this are usually very clear. The same tape can be used repeatedly, automatically replacing old dictation with new. It can be cut, edited, and stripped together with Scotch tape. Foot control attachment frees doctor's hands. Secretary uses same machine to play back for transcription. Price: $150-$350.

COME AND GET IT!

DELMOR® is a new and exceptionally useful formula for supplementing presurgical, obstetric, or convalescent diets with highest quality whole protein and other essential nutrients. A deliciously flavored powder, DELMOR may be given cooked or uncooked, with any kind of food, or between meals. Supplied in 1-lb. and 5-lb. bottles. Literature and recipes on request. Sharp & Dohme, Philadelphia 1, Pa.

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nutrient powder

SHARP & DOHME

A new formula for nourishment!

Delicious!

Concentrated!

Each 100 Gm. of DELMOR contains:

PROTEIN	(N x 6.25) derived from milk and soybean	50 Gm.
CARBOHYDRATE	derived from cane, milk and grain sugars and soybean	20 Gm.
MINERALS	Calcium	600 mg.
	Phosphorus	440 mg.
	Iron	15 mg.
VITAMINS	Thiamine HCl (vitamin B_1)	10 mg.
	Riboflavin (vitamin B_2)	10 mg.
	Pyridoxine HCl (vitamin B_6)	1 mg.
	Calcium pantothenate	5 mg.
	Niacinamide	100 mg.
	Ascorbic acid (vitamin C)	100 mg.
	Vitamin A	4,000 U.S.P. units
	Vitamin D	400 U.S.P. units
LIVER	Whole liver substance, together with other natural factors of the vitamin B complex, including vitamin B_{12}	1 Gm.

new!

FOR GREATER CALORIC INFUSION *specify*

Travert®

(INVERT SUGAR, BAXTER)

metabolized at *twice* the rate of DEXTROSE

Travert® (INVERT SUGAR, BAXTER) is another successful BAXTER *first*—a new line of solutions capable of supplying twice the calories of dextrose in equal infusion time, and without increased fluid volume.

And, since ***Travert***® is metabolized at twice the rate of dextrose, it is now possible and practical to approach complete carbohydrate alimentation.

Two ***Travert***® solutions are now available: 10% Invert Sugar w/v in water, and 10% Invert Sugar w/v in saline.

Travert® solutions are sterile, crystal-clear and non-pyrogenic.

Write today for literature and complete information.

Product of

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AMERICAN HOSPITAL SUPPLY CORPORATION

GENERAL OFFICES • EVANSTON, ILLINOIS

Will you want to use the machine outside your office? There are portable models that plug into any AC outlet. Some manufacturers will even install a machine under the dashboard of your car. Standard machines are of course less suited to out-of-the-office use.

How will you store recordings you want to keep? Some are easier to file than others. For example, cylinders are bulky, fragile; plastic discs and belts lie flat, don't break easily; wire and tape come in spools and reels, hold a lot of dictation for their size.

What is your secretary's opinion? After all, she'll be using the equipment almost as much as you.

Which Machine?

Once you know your specific needs, you're ready to look around. Here are some things to check while you're evaluating each type:

How clear is the recording? This is especially important if your secretary must do her transcribing within earshot of chattering patients.

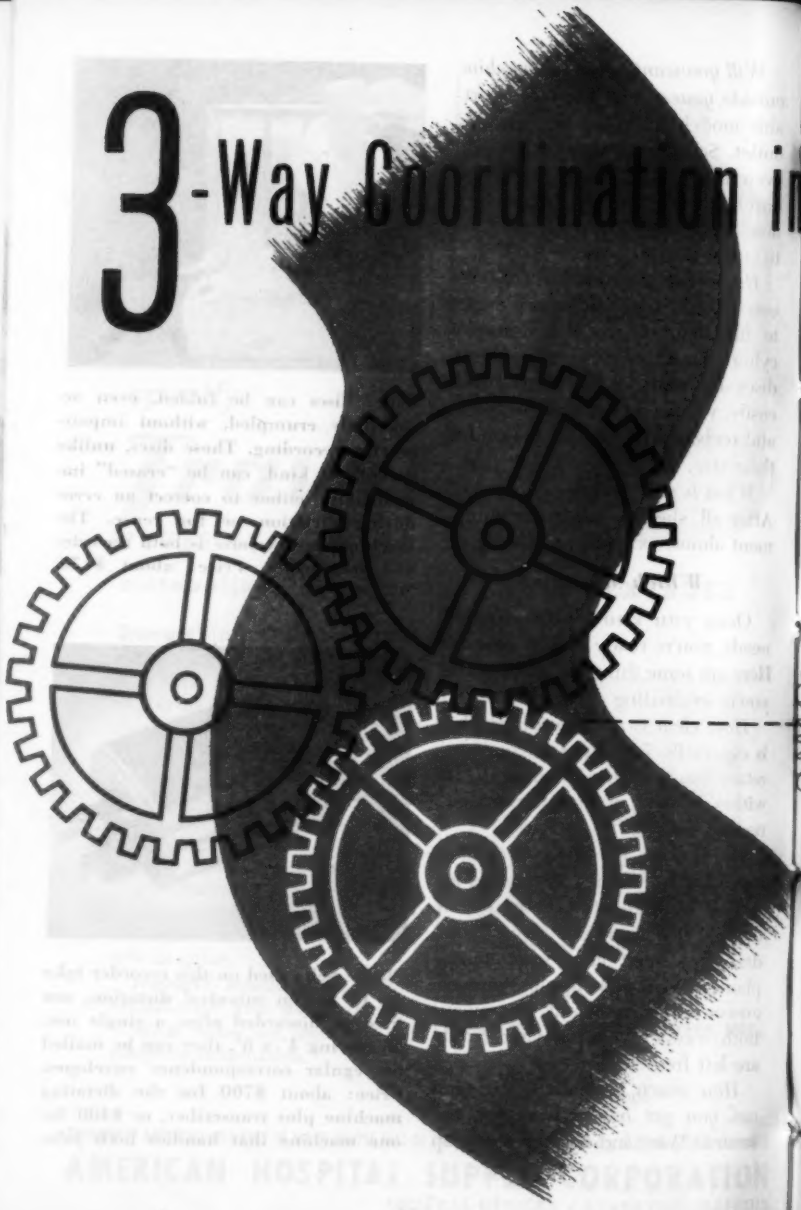
How close to the microphone must you be? Some table mikes let you sit back and talk naturally, as though to a patient across your desk. In a quiet office, some microphones even pick up low-pitched conversation several feet away. Both ways, of course, your hands are left free.

How much continuous dictation can you get before changing the record? Wire and tape give you up

Paper discs can be folded, even accidentally crumpled, without impairing the recording. These discs, unlike the plastic kind, can be "erased" immediately—either to correct an error during dictation or for reuse. The machine shown above is both recorder and transcriber. Price: about $170.

Plastic belts used on this recorder take up to fifteen minutes' dictation, are filed or discarded after a single use. Measuring 4" x 6", they can be mailed in regular correspondence envelopes. Price: about $700 for the dictating machine plus transcriber, or $400 for one machine that handles both jobs.

3-Way Coordination in H



in Hypertension Control...

RUTOL

(A BRAND OF RUTIN, PHENOBARBITAL AND MANNITOL HEXANITRATE, P.-M. CO.)

Coordinating effectively with your over-all plan of hypotensive treatment, Rutol provides safe drug medication designed to satisfy these vital objectives

1 • SEDATION

2 • VASODILATION

3 • CAPILLARY SUPPORT

Combined sedation and vasodilation are provided by the central effect of Phenobarbital and the direct, smooth muscle relaxing action of mannitol hexanitrate. Protection against capillary fragility[1] is provided by rutin—most active member of the flavone glucosides.

Each Tablet of Rutol contains:

Mannitol Hexanitrate	16 mg. (1/4 gr.)
Rutin	10 mg. (1/6 gr. approx.)
Phenobarbital	8 mg. (1/8 gr.)

Supplied in bottles of 100, 500 and 1000 tablets.

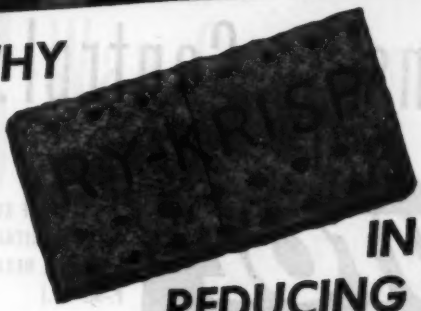
1. Donegan, J. M., and Thomas, W. A.: Capillary Fragility and Cutaneous Lymphatic Flow in Relation to Systemic and Retinal Vascular Manifestations: Rutin Therapy, Amer. J. Ophthalmology 31:671-78 (June) 1948.

PITMAN-MOORE COMPANY

PHARMACEUTICAL AND BIOLOGICAL CHEMISTS

Division of Allied Laboratories, Inc., Indianapolis 6, Indiana

WHY



IN THE REDUCING DIET

LOW-CALORIE! . . . only 23 calories per double-square wafer
NOURISHING! . . . . all the protein, minerals, B-vitamin of whole-grain rye
SATISFYING! . . . . . so crisp and "chewy" one naturally eats more slowly and is satisfied with less
FILLING! . . . . . absorbs moisture which increases bulk, delays hunger
DELICIOUS! . . . . . reducers enjoy it *without* "fattening" spreads

FREE Diet Booklets . . .

to save you hours of consultation time! Nutritionally sound, easy-to-follow guides to help overweights reduce safely.

"LOW-CALORIE DIETS" — 1200 calories for women; 1800 for men. Gives wide food choice, menus, recipes.

"THROUGH THE LOOKING GLASS" — 1500 calories. Especially written for teen-age girls. Gives recipes, menus, special tips.

USE COUPON TO ORDER

RALSTON PURINA COMPANY,
1E-D Checkerboard Square, St. Louis 2, Mo.
Please send (indicate quantity):

_____C 3049 "LOW-CALORIE DIETS" . . . for adults.
Imprinted with your name & address? ☐ Yes ☐ No
_____C 966 "THROUGH THE LOOKING GLASS" . . . for teen-age girls.

Name _____ M.D.
Street _____
City _____ Zone _____ State _____

to an hour. Discs and belts are better suited to shorter recordings.

Are earphones for transcribing available? Another point to consider if your girl doesn't have a room of her own.

Can you be sure the machine is actually recording what you say? Signal lights or buzzers on some types let you know when you're just talking for your own benefit.

How do you erase dictating errors or indicate corrections to be made? On some machines, you just switch back to the spot before the error and the machine erases the old recording as you make the new one. On others, you press a lever to mark the place where the correction (which you then dictate) is to be made.

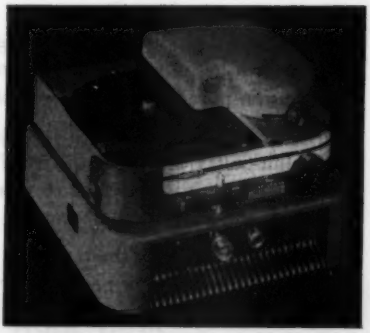
How do you locate snatches of dictation that you may want to review? Generally, it's not quite so easy to find selected passages on tape and wire because of the longer recordings they take.

Can the recording be mailed without fear of breakage? Away from the office, you may want to dictate letters to be sent to your secretary for typing and mailing.

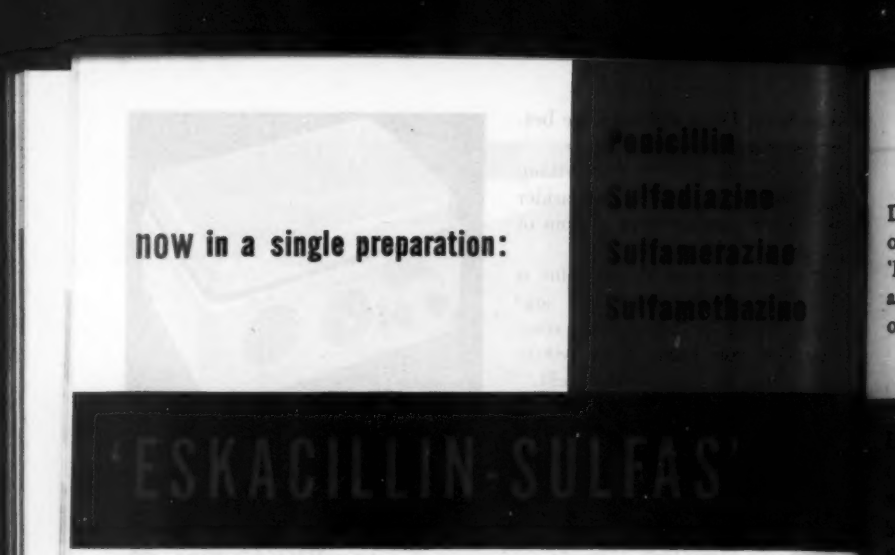
How many times can recording disc, belt, wire, or tape be reused without loss of clarity? Some are made to be used hundreds of times. Others, costing much less, are filed or discarded after one recording.

Can you get the machine on a trial basis? That's the safest way to find out if you've picked the right one—*before* you buy it. END

Wire can be reused indefinitely. On this type of machine, a new recording simply "erases" the previous one, making it easy to correct errors during dictation. The same machine is used for transcriptions. Price: $150-$275.



Plastic discs used on this type of machine are flexible enough for mailing. They can be used over and over or filed with individual case histories. Instructions for transcribing are made with grease pencil right on the disc itself. Discs, in various sizes, take from six minutes to over an hour's dictation. Price for a dictating machine like the above, plus transcriber: about $700; for a combination unit: about $400.



More and more physicians are turning to *combined penicillin-sulfonamide therapy;* for it has now been demonstrated that in many instances this combination *is more effective than—and offers many advantages over—the newer antibiotics.*

'Eskacillin-Sulfas' is leading the trend to this new and exciting combination therapy because it is presented to you in the most logical, easily-given and readily-accepted form: *an exceptionally palatable fluid.*

'Eskacillin-Sulfas' is for the treatment of infections caused by organisms sensitive to the action of penicillin or the sulfonamides. Among its many indications are:

Bronchitis	**Pneumonia**	**Sinusitis**
Tonsillitis	**Otitis Media**	**Gonorrhea**

You will also find 'Eskacillin-Sulfas' especially useful in urinary tract infections; bacillary dysentery; meningococcic infections; prophylaxis in streptococcal infections and rheumatic fever; as adjunctive therapy in pneumococcal meningitis and H. influenzae meningitis after the acute phase has subsided; prophylaxis in colonic surgery, surgical wounds and burns; and in certain resistant staphylococcal infections.

'Eskacillin' T.M. Reg. U.S. Pat. Off.

Due to its extremely wide antibacterial spectrum and the minimum chance of the development of resistant strains, many physicians find 'Eskacillin-Sulfas' the ideal therapy when immediate medication is necessary and lack of either time or laboratory facilities prevents exact determination of the specific organism involved.

Each teaspoonful (5 cc.) of 'Eskacillin-Sulfas' contains:

Crystalline potassium penicillin G	100,000 U.
Sulfadiazine	0.167 Gm.
Sulfamerazine	0.167 Gm.
Sulfamethazine	0.167 Gm.

'ESKACILLIN-SULFAS'

the original presentation of penicillin and the sulfonamides in fluid form Available in 2 fl. oz. bottles

Smith, Kline & French Laboratories, Philadelphia

why 'Eskacillin-Sulfas' is in fluid form:

We concluded—after weighing every possibility—that 'Eskacillin-Sulfas' should be a *fluid* for the following reasons:

1. Tablets are impractical because the bulky nature of the sulfonamides makes it virtually impossible to manufacture a small, easily-swallowed tablet.
2. The fluid form assures more rapid attainment of therapeutic blood levels.
3. A palatable fluid is the ideal form for children and for the many adults who balk at, or have difficulty with, tablet medication.

'Eskacillin-Sulfas' is so pleasant tasting your patients will find it easy to take whatever amount you prescribe—and, because of its fluid form, you will find it easy to adjust the dosage.

How to Read a Balance Sheet

Understanding a financial fever chart is not so hard as you might think

● All well-run organizations that handle money—business concerns, medical societies, hospitals, etc.—describe their dollar operations by means of (1) an income statement and (2) a balance sheet. An income statement is a moving picture of financial activities over a period of time. A balance sheet is a still photo of financial condition on a given date—ordinarily the last day of the period covered by the income statement.

Take a look at the sample balance sheet on the opposite page. Note that assets exactly equal liabilities. They always do. Here's why:

When true liabilities (debts) are subtracted from assets, the difference is also listed in the liability column, making a balance inevitable. This difference is called *net worth*. It consists of the par or stated value of stock issues, surplus, and reserves created from surplus.

What if there's a deficit instead of a surplus? In this case the accountants fix things so the two sides of the balance sheet will be equal anyhow. Whereas a surplus is added to other liability items, a deficit is subtracted from them. (It may even be listed on the asset side, added to genuine assets—again, merely for the sake of achieving a balance. But indicating a deficit in this manner is poor accounting practice and should make you leery of the whole balance sheet.)

The main point to remember is this: Though every balance sheet seems to balance, none really does. In fact, it's the degree and nature of the unbalance in various parts of a balance sheet that reveals the financial strength of the organization.

Current Ratio Gives Clue

First, note the unbalance between the Nonesuch Manufacturing Company's current assets of $8,946,000 and its current liabilities of $1,562,000. Current assets divided by current liabilities give you what's called the *current ratio*. In this case it's better than five to one; that is, the company's current assets cover its current liabilities more than five times over. The implication is that the concern certainly isn't in danger of going broke in the near future. *[Turn page]*

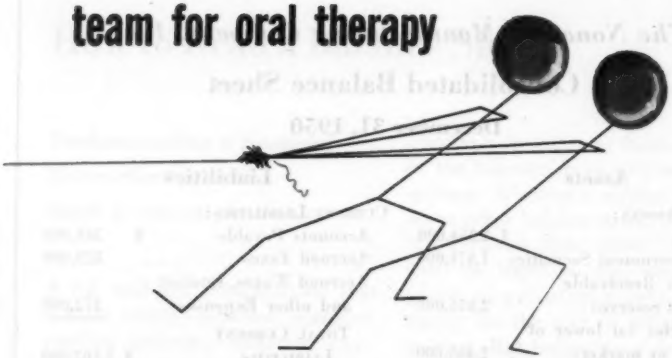
The Nonesuch Manufacturing Company, Inc.

Consolidated Balance Sheet

December 31, 1950

Assets			Liabilities		
Current Assets:			**Current Liabilities:**		
Cash		$ 2,254,000	Accounts Payable	$ 361,000	
U.S. Government Securities		1,371,000	Accrued Taxes	829,000	
Accounts Receivable (less reserve)		2,856,000	Accrued Wages, Interest and other Expenses	372,000	
Inventories (at lower of cost or market)		2,465,000	Total Current Liabilities		$ 1,562,000
Total Current Assets		$ 8,946,000			
Investment in Affiliated Company—			**First Mortgage Sinking Fund Bonds, 3½% Due 1966**		2,154,000
Not consolidated (at cost, not in excess of net assets)		234,000	**Reserve for Contingencies**		250,000
Other Investments (At cost, less than market)		126,000	**Capital Stock:**		
Sinking Fund		550,000	5% Preferred Stock (authorized and issued 10,000 shares of $100 par value)	$1,000,000	
Property, Plant and Equipment:			Common Stock (authorized and issued 400,000 shares of no par value)	1,000,000	2,000,000
Cost	$8,531,000		**Surplus:**		
Less Reserve for Depreciation	5,246,000	3,285,000	Earned	$5,613,000	
Prepayments		52,000	Capital (arising from sale of common capital stock at price in excess of stated value)	1,900,000	7,513,000
Deferred Charges		121,000			
Patents and Goodwill		165,000			
Total		$13,479,000	Total		$13,479,000

team for oral therapy



The daily administration of one or two Tablets MERCUHYDRIN® with Ascorbic Acid usually produces adequate diuresis in the cardiac patient whose water and electrolyte balance *has already been stabilized by parenteral mercurial diuretic therapy.* At this stage, the edema-free state — manifested by the unfluctuating basic weight — can be maintained with the tablets, either alone or supplemented by injections at appropriate intervals.

Such a schedule now gives time-honored digitalis a worthy partner in the fight against the failing heart. Maintaining the cardiac patient free of signs and symptoms of failure is facilitated by dual oral therapy — MERCUHYDRIN Tablets with Ascorbic Acid teamed with oral digitalis preparations.

tablets

MERCUHYDRIN

with Ascorbic Acid

(Brand of Meralluride)

The systematic use of MERCUHYDRIN Tablets with Ascorbic Acid simplifies treatment for patient and physician — injections are considerably reduced or eliminated, and visits to the physician's office are kept to a minimum.

packaging

Tablets MERCUHYDRIN with Ascorbic Acid, available in bottles of 100 tablets. Each tablet contains meralluride 60 mg. (equivalent to 19.5 mg. mercury) and ascorbic acid 100 mg.

Lakeside Laboratories, INC.

MILWAUKEE 1, WISCONSIN

For current liabilities are simply debts that will fall due within the next year, and current assets are the funds that will be available to meet them (cash, or securities that can be turned into cash quickly, plus assets that will be converted into cash in the ordinary course of business).

What constitutes a strong current ratio? Certainly five to one isn't bad. But what about three to one? Or two to one? Or less?

Financial men generally cast a fishy eye on a ratio of less than two to one. Beyond that, much depends on the kind of business the company is in. In recent years leading chemical concerns have shown ratios of around three to one; tobacco companies, four to one; railroads, two to one.

A company can operate safely on a low ratio (1) if it does not have to carry very large inventories in relation to total current assets and (2) if its accounts receivable (bills owed by customers) are small and easily collectible. To judge the current ratio of a company, compare it with the current ratios of other, similar companies.

What Quick Assets Show

Another measure of the strength of an organization is the relation between *quick assets* and current liabilities. Quick assets are current assets less inventories. For the Nonesuch Company they amount to $6,481,000, or more than four times the current liabilities. This is an unusually strong ratio. The general rule is that quick assets should at least equal current liabilities.

The difference between current assets and current liabilities is called *working capital*—$7,384,000 in the case of our sample company. Many investment analysts believe that an industrial concern should have a working capital at least equal to the face value of its outstanding bonds and preferred stocks. Nonesuch's working capital is 2.3 times the stated value ($3,154,000) of its bonds and preferred stocks.

Asset Breakdown

Now take a closer look at current assets. The figures for cash and U.S. Government securities may be considered as above suspicion if the company's financial statement has been certified by a reputable auditing firm.* Note that the value of accounts receivable is given only after prior deduction of a reserve for bad debts; while we don't know how much this reserve is, at least it's clear that the company

*The auditor's job is to check the company's books and certify that its financial statements fairly reflect its financial condition. One thing he does is to satisfy himself that the company has all the cash and Government bonds it says it has. He also spot-checks ownership of the other assets claimed. He may, for example, visit some of the company's warehouses, checking at random the goods listed in its inventory accounts.

While an audited statement is more to be trusted than a non-audited one, even the best public accounting firms have at times been hoodwinked. One notorious case was that of a leading pharmaceutical house whose president mulcted it of millions before the auditors caught up with him.

Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

MARTIN H. SMITH COMPANY
150 LAFAYETTE STREET, NEW YORK 13, N. Y.

ERGOAPIOL (SMITH) with SAVIN

INDICATIONS
Dysmenorrhea, dysmenorrhea, menorrhagia, metrorrhagia, and metrostaxis.

DOSAGE
1-2 cap. 3-4 times daily

SUPPLIED
In bottles of 20 and

The Preferred Uterine Tonic

isn't proceeding on the starry-eyed assumption that it will suffer no credit losses. Again, certification by a well-known public accounting firm would suggest that the reserve is of realistic proportions.

Inventories a Guide

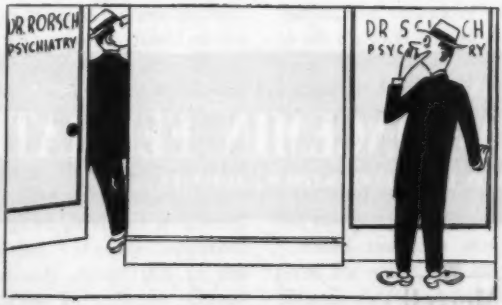
Of all current assets, inventories are worth the closest look. Their size and the way they're valued has a lot to do with the profits or losses the company will show later.

The accepted and conservative way to value inventories is as None-such has done—at whichever figure is lower, the price the company paid for its inventory materials or the price such materials currently bring in the open market. Thus, it might list some materials at the first figure, others at the second.

Are the company's inventories top-heavy? Has it stocked up on a lot of goods on which it may take a loss if a depression comes along?

You can get some idea on this by dividing the inventory figure into the company's latest annual sales figure (found in its income state-

"Good Morning"



"Now what did he mean by that?"

NOW...

B12 *activity, orally,*

IN A BLOOD-BUILDING,
APPETITE-BUILDING IRON TONIC!

- B_{12} activity of at least 12 micrograms of vitamin B_{12} per oz. as determined by microbiological assay.
- Iron (ferrous gluconate) in hematinic quantities.
- B complex vitamins well in excess of known minimum daily requirements.
- Pleasant tasting, too!

ELIXIR CAPSULES

BETA-CONCEMIN FERRATED

IRON B COMPLEX WITH B_{12} ACTIVITY

Merrell
1828
CINCINNATI • U.S.A.

Beta-Concemin®

ment). Suppose the result, called *inventory turnover*, is five. How does this figure compare with that of other companies in the same industry?

If it's much too low, taken against the average, the company may be sticking its neck out, over-committing itself in inventories. If it's far too high, this may mean the outfit is living from hand to mouth on raw materials, might get stuck in case of shortages or strikes by its suppliers.

What's It Worth?

Now for the other assets:

First is a $234,000 investment in an affiliated company. We don't know what the investment is worth today; only what was paid for it. However, the phrase "not in excess of net assets" suggests that the purchase price was a reasonable one in the light of the affiliated company's own balance-sheet position (*net assets* being those available for stockholders after deduction of all creditors' claims).

Chances are that Nonesuch holds less than 50 per cent control of this other company. Otherwise Nonesuch would class it as a *subsidiary* and include all the company's assets and liabilities in the Nonesuch balance sheet. It has already done this with other subsidiaries. That's why its balance sheet is labeled "Consolidated." It's also apparent that Nonesuch owns 100% of the stock of these subsidiaries. Otherwise, the consolidated balance sheet would show under liabilities the item "Minority Interest," representing the equity of other stockholders in the subsidiaries.

The next item, "Other Investments," presumably consists of miscellaneous stocks and bonds. Why not carry them as current assets? It's more conservative not to, since their market isn't so reliable as that for Government bonds. Also, Nonesuch may intend to hold them more or less permanently, as it probably does its investment in the affiliated company; if so, tagging them as current assets would be doubly misleading. The notation that they're carried "at cost, less than market" means that the company has a paper profit on them.

The company's "Sinking Fund" is also probably invested in securities. Sole purpose of this fund is to pay off the company's bonds (shown on liability side of the balance sheet), which fall due sixteen years hence.

Under an agreement it made when it sold these bonds to the public, the company was required to set up such a fund and add to it each year. Under the agreement, failure to do so, like failure to pay interest, would probably throw the company into bankruptcy. The bondholders have the further protection of a first mortgage on all the company's *fixed assets*.

Fixed assets is simply another term for what, on the Nonesuch balance sheet, is labeled "Property, Plant and Equipment." Note that

from the first soft whisper....

When pregnancy is *first* diagnosed, the need for *increased* amounts of calcium, phosphorous, iron and vitamins is already present.

OBron—specifically designed for the OB patient—provides balanced proportions of calcium, phosphorous, iron and vitamins to meet the added nutritional demand of the mother and to safeguard the optimal development and growth of the fetus.

Especially beneficial during the period of lactation, OBron supplies adequate vitamins and minerals to protect the nutritional state of the mother and insure an optimal content of these nutrients in the milk for the nursing child.

OBRON.....

CALCIUM • IRON • PHOSPHORUS • VITAMINS...ALL IN ONE CAPSULE

*Dicalcium Phosphate, Anhydrous...	*768 mg.*	Vitamin B_2 (Riboflavin).....	*2 mg.*
Ferrous Sulphate U.S.P.....	*64.8 mg.*	Vitamin B_6 (Pyridoxine Hydrochloride)	*0.5 mg.*
Vitamin A (Fish-Liver Oil)...	*5,000 U.S.P. Units*	Vitamin C (Ascorbic Acid).....	*37.5 mg.*
Vitamin D (Irradiated Ergosterol)	*400 U.S.P. Units*	Niacinamide.....	*20.0 mg.*
Vitamin B_1 (Thiamine Hydrochloride).	*2 mg.*	Calcium Pantothenate.....	*3.0 mg.*

*Equivalent to 15 grains Dicalcium Phosphate Dihydrate

J. B. ROERIG & COMPANY ETHICAL PHARMACEUTICALS ROERIG 536 N. Lake Shore Drive • Chicago 11, Ill.

these are carried at cost, less a reserve for depreciation. This depreciation reserve is a liability (in effect, a hole in the assets) and may appear on the liability side of the balance sheet. But the way Nonesuch has handled it, subtracting the reserve directly from the assets it applies to, makes for easier reading of the balance sheet. In either case the effect is the same—to allow for the fact that buildings and machinery wear out or become obsolete, and have to be replaced.

Depreciation charges are a regular annual expense item. Of course, there's no assurance that the money thus theoretically set aside will be enough to pay for worn-out buildings and machines (for prices may have risen). But failure to charge depreciation would give a false statement of earnings, since the company would be living partly off its own fat. Similar to depreciation are charges for *depletion* by companies that operate mines or oil producing lands.

"Prepayments" and "Deferred Charges" both represent money the company has paid out for services or benefits yet to be received. Rent or insurance premiums paid in advance are an example of prepayments. And a typical deferred charge would be the development costs of a product not yet ready for market.

Instead of treating such costs as an expense of the year they're incurred, the company will pro rate them over several future years when the product is actually on sale. Meanwhile, believing these expenditures a valuable investment for the future, it carries them as an asset on its balance sheet. The cash account is reduced by the amount of the development expenditures; the deferred charges account is increased by the same amount.

In reading any balance sheet, remember that many of the figures are arbitrary. Accountants are the first to admit this. They point out that for some assets there's no way of calculating true value—*i.e.*, what they'd bring if offered for sale. An example is fixed assets, commonly listed at cost (which is ancient history) less depreciation (largely guess work). An even better example is "Patents and Goodwill" (often called *intangibles*).

Clearly these items are worth something, in some cases a great deal. But how much?

Some companies, even though owning important patents and

trademarks of immense goodwill value, exclude such items from their balance sheets, or value them at a nominal $1. Examples: Reynolds Tobacco (Camels), Procter & Gamble (Ivory Soap), Montgomery Ward, U.S. Steel. Not that this is by any means a rule. The American Tobacco Company (Lucky Strikes), for instance, values its intangibles at $54 million; Coca Cola, $39 million; du Pont, $42 million.

The point is that the value of intangibles is anybody's guess. That's why they're customarily left out of the picture in computing the *book value* of a company's securities.

Margin of Safety

The book value of a security is the money that would be available to pay it off, after first paying off all senior claims, if the company's tangible assets were sold at prices equal to their book (balance sheet) valuation. For instance, Nonesuch has 2,154 bonds outstanding, each of $1,000 face value. Its tangible assets ($13,314,000) less its current liabilities ($1,562,000) leave $11,752,000 to pay off the bonds. Dividing this figure by 2,154, we find that each bond is backed by $5,456 worth of assets.

In actual liquidation, of course, each bond would be entitled to only $1,000. The $5,456 figure merely indicates the margin of safety that the bondholders enjoy—in this case an ample one.

Book value of other securities is

USE THIS NEW HEXACHLOROPHENE SOAP

As an Adjunct
In Treating
Pyogenic Infections

As a Skin Antiseptic
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(HEXACHLOROPHENE)

Surgical Soap

ANOTHER ETHICON QUALITY PRODUCT

ETHICON SUTURE LABORATORIES, INC.
NEW BRUNSWICK, NEW JERSEY

Gamophen Hexachlorophene Surgical Soap has been accepted by the Council on Pharmacy and Chemistry of the American Medical Association. It is a highly purified detergent soap containing hexachlorophene, an efficient antiseptic that adds to the cleansing action of the soap a bactericidal and cumulative bacteriostatic effect, even in high dilution.

Because of its prolonged antibacterial suppressive action, it has been found not only to be an excellent agent for preparing the hands of the surgeon in the operating room, but also a valuable adjunct in the treatment of certain skin conditions involving pus-forming infections.

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(May be clipped and pasted to Penny Post Card)

ETHICON, New Brunswick, N. J. DEPT. ME-151
Please send Gamophen Soap and Literature.

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Limited to Profession in U.S.A.

THE OVER 40 ARTHRITIC

Many a case of painful arthritis in the "over 40" age-group—those most susceptible to gouty arthritis—will respond to Cinbisal.

Cinbisal combines colchicine with salicylate—both effective in producing urate diuresis and relieving arthritic pain. Inclusion of a protective dose of ascorbic acid assures adequate replacement of this essential factor during salicylate therapy.

EACH TABLET CINBISAL CONTAINS:

Colchicine	0.25 mg. (1/250 gr.)
Sodium Salicylate	0.3 Gm. (5 gr.)
Ascorbic Acid	15 mg.

SUGGESTED DOSAGE:

One or two tablets every four hours.

SUPPLIED: Cinbisal is available in bottles of 100 and 1000 tablets (Engestic® coated green).

Samples on request.

CINBISAL

'McNEIL'

*Trade-Mark of McNeil Laboratories, Inc.

for "This wormy world"

Diphenan

209 MILLION persons act as hosts to Oxyuris (Enterobius) vermicularis according to Stoll's fascinating article "This Wormy World".[1] This undesirable tenancy can be terminated with the aid of 'Tabloid' brand Diphenan, by mouth, for Diphenan is an effective anthelmintic.

Since these worms make no distinction as to age or social status—Diphenan's palatability, safety and economy are important considerations. One or two products t.i.d. for adults; ¼ of a product t.i.d. for children up to 3; ½ t.i.d. for children up to 10, and 1 t.i.d. for older children. 'Tabloid' brand Diphenan is supplied as wintergreen-flavored chewing wafers of 0.5 grams each in bottles of 20.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE 7, N.Y.

1. Stoll, Norman R.: Jrl. of Parasitology 23:1 No. 1 (Feb.) 1947.

computed the same way. Thus, each share of $100-par preferred stock is backed by $960 in assets ($11,752,000 of net tangible assets minus $2,154,000 face amount of bonds [leaving $9,598,000], divided by 10,000 shares of preferred). Book value of the common stock is $21.50 ($9,598,000 minus $1,000,000 par value of the preferred [leaving $8,598,000], divided by 400,000 shares of common).

But the book value of a common stock has limited bearing on its market value. Common stock prices respond more to earnings-and-dividends prospects, ignore book values as academic. Exceptions are the shares of banks, insurance companies, and investment trusts. Their assets, instead of being factories or railroad lines of unknown auction worth, are mostly cash and securities, subject to accurate valuation. Here book value is some indication of true value, and the market pays it some attention.

Stockholders' Rights

Note that on the Nonesuch balance sheet both the common stock and the preferred stock are labeled "Capital Stock." A company may have many kinds of stock outstanding—preferred, preference (means the same), prior preferred (ranks ahead of some other preferred issue), class A, class B (usually signifies a difference in voting powers), common stock, capital stock, founders' shares, etc.—but the generic term is *capital stock*.

Essentially, any kind of stockholder is a joint owner of the company, a proprietor of the business. A bondholder, however, is a creditor; he's merely loaned the company money, not bought an interest in it.

Preferred stock is so called because it has first call on dividends. Nonesuch can't pay anything to its common stockholders unless it first pays the full annual rate ($5 per share) to holders of the preferred. Often, in lean years, preferred stockholders get paid, common stockholders don't.

When times get *too* lean the company may quit paying preferred stockholders too. They can't toss the company into bankruptcy for this (as bondholders can if they don't get their interest). But preferred dividends are usually *cumulative*. This means that, before the company can start paying its common stockholders again, it must settle up all dividend arrears on the preferred stock. And, if the company decides to liquidate, preferred stockholders usually get paid off (up to the par value of their shares) ahead of the common stockholders—who get what's left, if anything.

But preferred stockholders can never be paid more than their fixed dividend rate. For common stockholders, the sky's the limit. That's why, when a company prospers, common stockholders may do a lot better than preferred holders. Also, they have voting control of the company—unless it falls behind on

As a primary dietary supplement for the pregnant patient— there is nothing better than—

White's MOL-IRON®

with CALCIUM and VITAMIN D

Mol-Iron—most effective iron therapy known,[1,2,3] now has been supplemented with the essential gestational elements, calcium and phosphorus, in an optimum ratio, plus adequate vitamin D.

The superiority of Mol-Iron as a source of iron is epitomized in the conclusions of Dieckmann:[1] "We have never had other iron salts so efficacious in pregnant patients."

Each easily-swallowed, soft gelatin capsule contains:

Mol-Iron	198 mg.
Dicalcium Phosphate (anhydrous)	869 mg.
Vitamin D_2	200 units

Prophylactic Dose: one capsule three times daily after meals.
Therapeutic Dose: two capsules three times daily after meals (providing 240 mg. Fe^{++} daily).

Supplied: Soft gelatin capsules in bottles of 100.

ALSO *Supplied:*
Mol-Iron Tablets in bottles of 100 and 1000.
Mol-Iron Liquid in bottles of 12 fluid ounces.
Mol-Iron with Liver and Vitamins, capsules, in bottles of 100.

White Laboratories, Inc., Pharmaceutical Manufacturers, Newark 7, N. J.

1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet & Gynec. *57*:541 (1949).
2. Cheeley, R. F., and Annitto, J. E.: Bull. Margaret Hague Mat. Hosp. *1*:68 (1949).
3. Dieckmann, W. J. et al: Am. J. Obstet. & Gynec. *59*:442 (1950).

preferred dividends. Then there may be a provision for the preferred stockholders to take over control.

The $1,000,000 figure that Nonesuch places opposite its preferred stock is logical enough (because the 10,000 preferred shares are entitled to $100 each in liquidation). But the $1,000,000 for the common stock is virtually meaningless.

Dividing 400,000 into $1,000,000, we know that the *stated value* of the stock is $2.50 per share. But stated value is merely a figure the company picks out of the air. Actually, it sold the stock originally for an average of $7.25 a share (stated value of $1,000,000 plus capital surplus of $1,900,000 [$2,900,000] divided by 400,000 shares).

The entire surplus account is reserved to the common stockholders. The part marked "Earned" represents accumulated profits in excess of what have been paid out in dividends over the years.

Why separate earned surplus from capital surplus? Because, if they were lumped together, a balance-sheet reader might easily assume that the company had earned and saved the whole amount. Also, companies do not ordinarily pay dividends out of capital surplus, even where the law allows them to.

Under liabilities, Nonesuch also lists a "Reserve for Contingencies." This, too, represents part of the common stockholders' stake in the company. If the company had a fire loss in excess of insurance coverage, it would probably write off the loss against this reserve.

Setting up such a reserve is merely an accountant's way of saying, "We mustn't think of our surplus as being as big as it really is. Let's set part of it aside in recognition of some of the nasty things that could happen to us." So they lop $250,000 off the surplus account and call it a contingency reserve. It is not available for payment of dividends.

Watch Capital Ratios

Worth noting in any corporate balance sheet is the proportion of each class of security to the total capital structure (bonds, preferred stock, common stock, contingency reserve, and surplus). For Nonesuch, the bond ratio ($2,154,000 of bonds divided by $11,917,000

"I'm only paying the doctor for my *last* visit. That's the one that cured me."

"a unanimous decision"

Eskadiamer tastes good!

Children—and adults—actually like to take Eskadiamer because it is so unusually pleasant tasting . . . and because it is not thick and cloying but light and easy to swallow.

Eskadiamer contains equal parts of sulfadiazine and sulfamerazine—the two safest sulfonamides in general use.

Since Eskadiamer is an aqueous suspension of microcrystalline sulfadiazine and microcrystalline sulfamerazine, desired serum levels are attained much more rapidly than with sulfonamide tablets of equivalent dosage.

Smith, Kline & French Laboratories, Philadelphia

Eskadiamer *the delicious fluid preparation of sulfamerazine and sulfadiazine*

'Eskadiamer' T.M. Reg. U.S. Pat. Off.

Each 5 cc. (one teaspoonful) of ESKADIAMER contains 0.25 Gm. (3.86 gr.) microcrystalline sulfamerazine and 0.25 Gm. (3.86 gr.) microcrystalline sulfadiazine—the dosage equivalent of the standard 0.5 Gm. (7.7 gr.) sulfonamide tablet.

total capitalization) is 18 per cent; the preferred stock ratio, 8 per cent; the common stock ratio, 74 per cent.

For an industrial company this is a reasonably conservative capital set-up.

Bonded Debt

Financial men generally consider a bonded debt of more than 25 per cent of total capitalization excessive for an industrial company. Also, they feel that bonds and preferred stocks combined should not represent more than 50 per cent. But railroads and utilities are permitted somewhat higher senior-security ratios. Generally speaking, the smaller the common stock ratio, the more speculative the investment quality of the company.

A corporation balance sheet, like Nonesuch's, is not essentially different from that of a medical society or a partnership. But the latter, while it might have bonds outstanding, would not have capital stock.

What does a balance sheet show? By itself, not much. In comparison with previous balance sheets, somewhat more. If the company is in sound financial health, that much should be apparent; if it's teetering on the edge of the grave, that should be evident too.

But to tell whether its health is improving or declining, you must have a look at the company's income statement. Usually it's issued along with the balance sheet.

—H. D. STEINMETZ

NOTE: *This is the first of two articles on how to read financial reports. The second will deal with income statements.*

What is

GANTRISIN

1 A new, *safer* sulfonamide with a *wider* antibacterial spectrum.

same indications as other sulfonamides?

2 More; it has been effective in some infections not responsive to other sulfonamides and antibiotics.

how about toxicity?

3 High solubility prevents renal blocking. Incidence of other reactions is also very low.

N'ROCHE'?

should the patient be alkalized?

4 Not necessary with Gantrisin® because of its high solubility.

how about cost?

5 Gantrisin is so economical that it can be prescribed without straining the patient's budget.

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VASCUTUM

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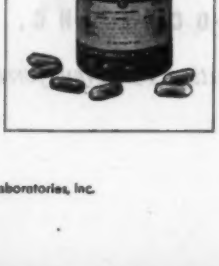
for the life that begins at forty

VASCUTUM* makes possible a dual attack—both prophylactic *and* therapeutic—in the two-front battle against hypercholesterolemia and capillary fragility. VASCUTUM combines in one medication:

▶Potent amounts of lipotropic agents, to promote decholesterolization in atherosclerosis, cirrhosis and diabetes mellitus.

▶Therapeutic amounts of rutin and ascorbic acid, to combat related capillary weakness effectively. Damaging retinal hemorrhage often results from excessive capillary fragility and associated abnormal cholesterol deposits.

A daily dose of 6 tablets provides:			
Choline	1 Gm.	Pyridoxine HCl	4 mg.
Inositol	1 Gm.	Rutin	150 mg.
dl-Methionine	500 mg.	Ascorbic Acid	75 mg.



VASCUTUM is another Schenley Laboratories contribution marking a distinct advance in the management of interrelated degenerative diseases clinically prominent in the middle-aged and elderly.

SUPPLIED in bottles containing 100 tablets.

SCHENLEY LABORATORIES, INC.
350 FIFTH AVENUE • NEW YORK 1

*The word VASCUTUM is a trademark of Schenley Laboratories, Inc.

Your Practice Five Years Hence

[*Continued from* 59]

In county medical societies, the G.P. stands to retain the share of leadership he now has. But state societies, except in thinly-populated regions, are not likely to number many G.P.'s in their high commands—if for no other reason than that the time demands of such offices are too taxing for a G.P. with a round-the-clock schedule.

Specialty Bound?

Specialists have for several years been on the defensive. One result has been a jacking-up of recognition standards. The American board diploma is becoming not only more prized but harder to get.

A few decades ago, most specialist societies were eager to expand. So they accepted any reputable physician who expressed genuine interest in the field.

Today, membership committees are more critical, and the rate of rejected applicants is mounting. In courtrooms, medical schools, hospitals, and government agencies, the word "specialist" is rapidly becoming a synonym for "board diplomate."

Some of today's senior consultants graduated from general into specialized practice. If that's your status, it won't be disturbed. But by 1956 this will be an obsolete way of entering a specialty.

If you're setting your sights on a specialty now, expect to devote three or four years to a residency. If you can't afford to do that, chances are you'll find the door to specialization pretty tightly closed.

Doctor vs. Hospital

Medicine will be more successful in its struggle against socialized medicine than against hospital encroachment. Since the end of World War II there has been a steady rise in the number of doctors practicing medicine in hospitals. They work as salaried employes or as tenants in "private-office" space furnished by the hospital.

The success of Blue Cross aggravates the problem. Roentgenologists, anesthesiologists, and pathologists have for years been rendering medical services that appear on the hospital bill. Other specialists are now finding themselves in the same boat.

You have probably heard of an occasional hospital adding an obstetrician to its payroll or acquiring a brain surgeon as an office tenant. But have you ever heard of a hospital discontinuing any previously offered medical service? Probably not.

The hospitals show no fear of organized medicine. They completely reject the thesis that the hospital is but a hotel for sick peo-

ple, a workshop for doctors.

Why have medical societies been less firm in supporting this thesis than in opposing compulsory health insurance? One possible answer is that some of the heads of organized medicine are also heads of hospital staffs.

Toward Group Practice

It seems reasonable to conclude that within five years hospitals will have vast control over the treatment of the seriously sick and over the more complicated diagnostic services. For these, the private M.D.'s office may have to function essentially as a referring station.

Best bet is that group practice, now on the march, will continue. To young specialists, it's economically attractive because they get a fully equipped office plus a ready-made practice, with little or no cash investment. It's also psychologically appealing, for it allows them to step into private practice yet continue the teamwork atmosphere of their hospital residency. An added advantage is that groups gear well into the contract type of practice favored by many industrial firms and government agencies.

Groups are as jealous as hospitals are of the professional standing of their staff members. They screen applicants for admission with meticulous care; and they're constantly upping their standards. More than 100 medical groups are said to have been started last year in California alone.

More Salaried Jobs

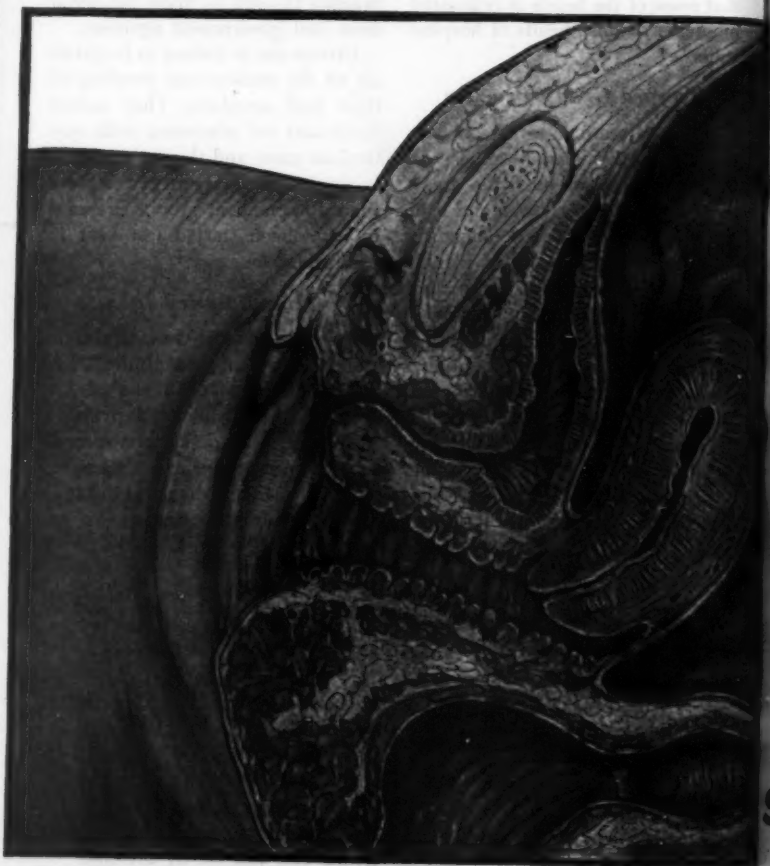
Salaried medical work is also on the rise. Just leaf through the "Physicians Wanted" columns of the Journal AMA. State and private hospitals, health departments, medical schools, groups and clinics, industrial plants, pharmaceutical houses, insurance companies, re-

No Deal

• A midwestern urologist was called out at 3 o'clock one morning to catheterize a patient in severe distress. A week later the man dropped by his office. "Don't you think, Doctor," he said, "that $10 is a bit steep for that visit?"

The physician promptly made him a proposition. "If you'll get up at 3 A.M. tomorrow, put on your clothes, back your car out of the garage, drive to my home, and just sit by my bed and talk to me for forty-five minutes, I'll call it square."

The patient thought it over for a moment. Then, reaching for his wallet, he grinned, "Do you think $10 is enough?"



"The thin, grey, foamy discharge associated with excoriation of the labia and vagina, strawberry spots on the cervix, and intense itching almost always means trichomoniasis. Trichomonas is associated with a mixed bacterial flora, but not necessarily with a purulent discharge."

—Passmore, G. G.: Treatment of Discharges from the Vagina in Private Practice, North Carolina M. J. 11:487 (Sept.) 1950.

floraquin® aims at restoring and maintaining a normal vaginal environment unfavorable to the growth of pathogenic organisms. Floraquin contains Diodoquin-Searle (diiodohydroxyquinoline), a potent trichomonacide and fungicide, combined with lactose, dextrose and boric acid adjusted to effect the reestablishment of the normal vaginal pH and, in turn, the normal flora. G. D. Searle & Co., Chicago 80, Illinois.

SEARLE

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PRULOSE® COMPLEX

The *dietary approach* for Therapeutic correction of Functional Constipation.

Combining the well-known bulk-producing effect of methylcellulose with the universally accepted laxative properties of prunes, the *natural laxative food*, fortified with an isatin derivative. This activated moist bulk

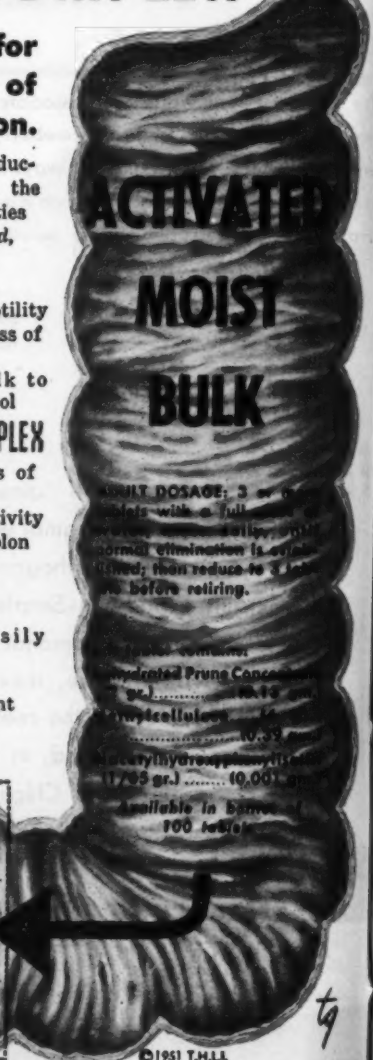
1. activates the colon to normal motility
2. prevents drying out and hardness of the colon contents
3. supplies the necessary bulk to increase the volume of the stool

These actions of PRULOSE COMPLEX

1. promptly relieve the symptoms of functional constipation
2. gently stimulate peristaltic activity
3. institute a return to normal colon function

PRULOSE COMPLEX tablets are:

1. convenient, small and easily swallowed
2. economical—low dosage
3. formulated for maximum patient cooperation



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State.....

The HARROWER Laboratory, Inc.,
930 Newark Ave., Jersey City 6,
261-

search foundations, and the Federal Government—all are in the market for M.D.'s.

Salaries were never higher. In many specialties, the monthly paycheck for a qualified practitioner is $1,000. This is equal to a private practice gross of around $20,000 a year. And it's minus many of the headaches and the brutal tempo of private practice. Sometimes other incentives are included too, such as private consultation practice, professorial status, or living quarters.

Such work will continue to attract those younger doctors who don't relish the uncertainties of solo practice. It will also appeal to the older physician who wants to set a slower pace. More payroll signing by doctors thus seems a safe forecast.

Strong Medical Societies

Medical society membership is constantly gaining recognition as a sound way to establish one's status as a reputable and acceptable practitioner. It will be increasingly important to have this "status."

Society dues are likely to go up. As the associations expand their activities, so they will have to expand their budgets. Membership will cost more. But it will be worth more.

American doctors are not likely to sell their birthright so cheaply as did their British colleagues. Yet resistance to socialization will be successful only if organized medicine is strong. In spite of individual gripes about organizational bureaucracy, association politics, and high dues, most doctors in the next five years will continue to give their societies vigorous support.

Teamwork the Theme

To return now to the big, underlying change in practice in the next five years:

Medical men are going to have to work together far more closely than before. They are also going to have to work more closely with other professions and the laity. Many "outsiders" are on our team now, whether we like it or not.

The one-man medical attendant is on his way out. By 1956 the physician will be but a single member of a much larger health team. Chances are, though, that he will still be team captain.

—CHARLES MILLER, M.D.

"When you're going crazy, he helps you."

Don't Forget to Deduct Taxes!

A good many of them count as deductions from income on your Federal return

• Not *all* the taxes you paid in 1950 can be subtracted from taxable income on your current Federal form. But a number of such levies—Federal, state, and local—*do* count as deductions. Chief exceptions: (1) Federal income, estate, and gift taxes; (2) local benefit and inheritance taxes.

You may, for example, deduct these items:

¶ Federal social security taxes (unemployment and old-age benefits) that you paid as an employer. (You are not, of course, permitted to deduct the sums you were required to withhold from employes' wages.)

¶ State income taxes.

¶ City or state taxes on gasoline, personal property, cosmetics, and admissions.

¶ Cost of automobile licenses—both for car and for operator.

As for a real estate tax, three principles determine whether you're allowed to deduct it: (a) It must actually be a tax; (b) it must be imposed on you; (c) you must be the one who actually pays it. Thus, a special assessment on real property for local improvements (streets, sewers, etc.) is not considered a tax and therefore is not deductible. Neither is the misnamed "water tax" levied in some communities. (But if you maintain a home-office, part of the "water-tax" may be deducted as a professional expense.)

How to Compute

To justify a deduction, you're generally not required to keep detailed records of the so-called "nuisance" taxes. Income tax collectors know the virtual impossibility of recording such figures accurately. So you're usually allowed to compute your sales taxes on an estimate of total purchases made during the year. You may, as a rule, compute your gasoline taxes on your car's mileage during the year and on the average distance per gallon.

Not ordinarily deductible are Federal excise taxes on amusement admissions, dues, safe-deposit

---

* *The author, Alfred J. Cronin, is a member of the firm of Murphy, Lanier & Quinn, New York, accountants and tax consultants.*

A Curity PRODUCT

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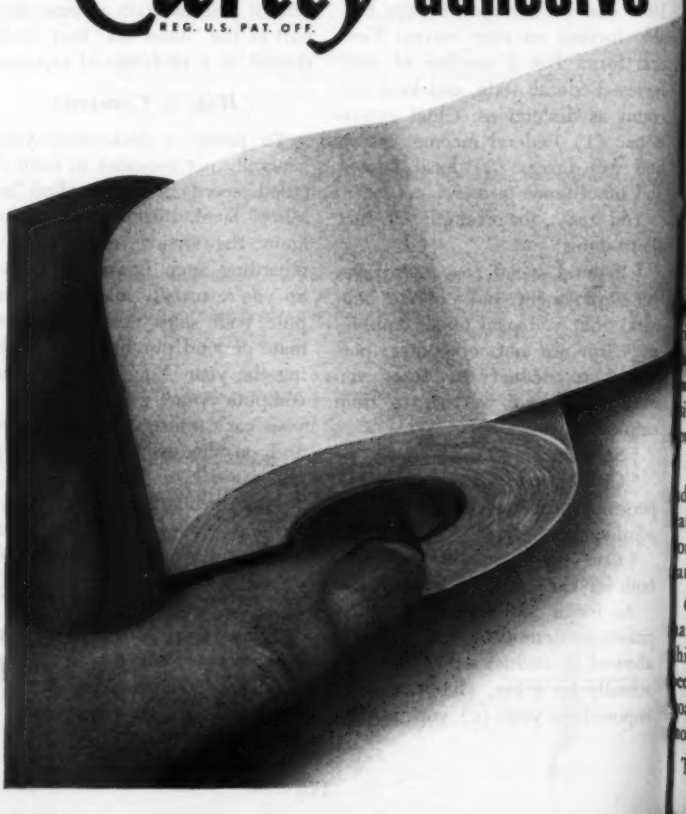
BAUER & BLACK

Now–an entirely new Curity adhesive

REG. U.S. PAT. OFF.



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Today,

A **Curity** PRODUCT

BAUER & BLACK

Today, a new and superior adhesive is available. It is prepared from a *completely new formula*. It contains the most expensive and highly refined ingredients purchasable.

Recent skin tests show this new adhesive causes even less skin irritation than the regular *Curity* brand formerly produced—the least irritating adhesive we have ever made.

Curity laboratory technicians have worked constantly to develop this new adhesive. There have been no restrictions. The single goal has been "the finest adhesive modern science can produce."

Today, that goal has been met.

The well-known *Curity* tackiness and adhesiveness have been improved! . . . but not at the expense of other qualities. It retains the same body for which *Curity* is noted . . . for easy application, freedom from wrinkling. And this new adhesive is yours at the same cost.

Curity

ADHESIVE

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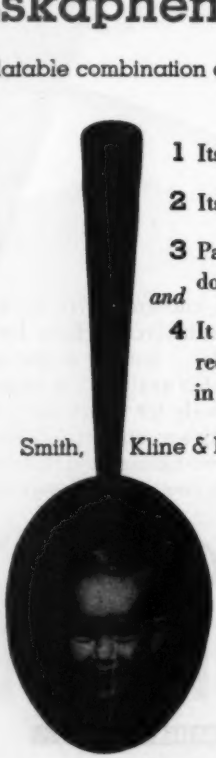
when you prescribe

phenobarbital

remember this superior presentation:

Eskaphen B Elixir the delightfully palatable combination of phenobarbital and thiamine



1 Its fluid form makes it easy to take

2 Its delicious flavor makes it pleasant to take

3 Patients who "know all about sleeping tablets" don't know you are prescribing a barbiturate

and

4 It provides nearly three times the recommended daily allowance of thiamine in each 5 cc. teaspoonful

Smith, Kline & French Laboratories, Philadelphia

Each 5 cc. teaspoonful contains phenobarbital, ¼ gr., thiamine, 5 mg.

'Eskaphen B' T.M. Reg. U.S. Pat. Off.

boxes, and transportation. But when you're entitled to deduct the basic outlay as a professional expense, you may also deduct the tax on it.

You're not allowed to deduct the Federal stamp tax on a security transfer. The Internal Revenue people require you to show it as an expense in computing capital gain or loss on the transaction.

When it comes to listing your taxes on the Federal income tax form, you often have a choice. You may list them as either a personal or a professional expense. Which is best?

As a rule, you save money by handling all taxes possible as professional expenses. This enables you to get credit for your outlays and, in addition, to take the full standard deduction. Here's an example:

Drs. A and B are both single and without dependents. In 1950 both had net professional incomes of $9,600 before any reduction for taxes. Both had allowable deductions of $1,000 in real estate taxes on home-offices, used half for personal and half for professional purposes.

Dr. A takes his $1,000 deduction as a personal expense, thus depriving himself of the standard deduction. His net taxable income becomes $8,600. His income tax amounts to $1,767.60.

Dr. B, on the other hand, counts half the $1,000 real estate tax as a professional expense. That makes his adjusted net income $9,100 and still lets him take the standard deduction—in this case, $910. His net taxable income becomes $8,190. His income tax amounts to $1,655.67.

Thus, Dr. B makes a saving of $111.93. —ALFRED J. CRONIN

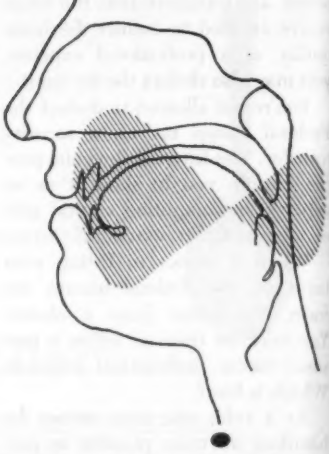
NOTE: *For a list of other professional tax deductions, see page* 141, *December* MEDICAL ECONOMICS.

Never Underestimate, Etc.

• A medical-school classmate of mine was taking the venous pressure of a cardiac. His eyes bulged as the mercury climbed higher and higher, finally to spill out of the top of the manometer. An overflow of saline and blood followed.

Muttering dazedly over such an astonishing venous pressure, he saturated sponge after sponge trying to stem the red tide. The last sponge gone, he made off post haste to the doctor's station. By the time he'd returned (with the senior resident, two assistant residents, and an interne) a little student nurse had released the tourniquet. —DANIEL CHOY, M.D.

Local treatment
of gingival infections
with the *newest*
of the broad-spectrum
antibiotics



CRYSTALLINE

Terramycin

TROCHES

Each troche provides 15 mg. of Terramycin in a pleasant-tasting, mint-flavored sugar base.

Particularly valuable in Vincent's infection, and as an adjunct to dental procedures in the treatment of pericoronitis and other mouth infections caused by a wide range of Gram-positive and Gram-negative bacteria.

Administration and Dosage

Daily dosage of 8 to 16 troches has been found adequate for most infections. A troche is placed in the lower gingivolabial groove and permitted to remain without sucking or chewing until completely dissolved.

Supplied: On prescription, in packages of 24.

Pfizer

Antibiotic Division
CHAS. PFIZER & CO., INC., *Brooklyn 6, N.Y.*

How Not to Pick a Location

Thinking of moving your office? Beware the pitfalls these M.D.'s encountered

• For either beginner or old hand, picking a new office locale is tricky business. Herewith a few actual case histories, each complete with object lesson . . . an example of what *not* to do when you move:

Rely on patients who say they'll follow you to your new location.

An Ohio G.P. with an office handy to the shopping center of town, had his eye on a suite in a small professional building seven blocks away. Over a period of months he asked his patients if they'd come to him in the new location. Nearly all said they would. The doctor signed up for the suite.

Before moving, however, he queried a business consultant. The latter didn't trust the patients' impromptu reactions. Some, he believed, might have answered with more tact than truth; others perhaps had replied without thinking.

At the consultant's suggestion, the doctor sent out a questionnaire. Each patient was asked how he ordinarily came to the doctor's office (by street car, bus, auto, or on foot). The returns showed that most patients used bus and trolley lines (none of which ran very close to the new location).

Against the consultant's advice, the doctor made the move anyhow, since he'd already rented the suite. Two months later he counted himself lucky to get back into his old office, forfeiting ten months' rent on the other place. For despite what patients had *said* they'd do, events proved they would not come to a place they couldn't reach easily.

Settle in a has-been neighborhood.

An Illinois physician bought a $30,000 house in a sedate neighborhood inhabited by the town's oldest families. Having prudently checked the zoning laws, he spent another $12,000 remodeling the place as an office-residence. He quickly became popular, and he thought he was set for life.

But in a few years the old families began dying off. Their elegant victorian homes could be disposed of only as rooming houses. The roomers could not support a practice like the doctor's. Result: He had to make a fresh start elsewhere, taking a heavy loss in the process. [*Turn page*]

arthralgen®

The topical use of Arthralgen brings quick comfort and lasting relief from muscle and joint pain through the combined synergistic effects of (a) rubefaction, (b) vasodilation, (c) analgesia.

PENETRATION SPEEDS ACTION

Selected low surface tension wetting agents in the ointment base encourage thorough, deep and rapid penetration of the contained medicaments.

FORMULA:

Arthralgen contains 0.25% methacholine chloride, 1% thymol, 10% menthol and 15% methyl salicylate, in a highly absorbable, washable, emollient base.

WIDE CLINICAL APPLICATION

Arthralgen has proved its value as adjunctive treatment in arthralgias, myalgias and neuralgias, including such typical disorders as sprains, lumbago, synovitis, bursitis, neuritis, myositis, sciatica, pleurodynia.

Arthralgen is supplied in 1-oz. collapsible tubes and ½ lb. jars.

Whittier LABORATORIES
CHICAGO 11, ILLINOIS

A similar problem sometimes crops up when a young practitioner joins a much older one. Take this father-and-son case in Utah:

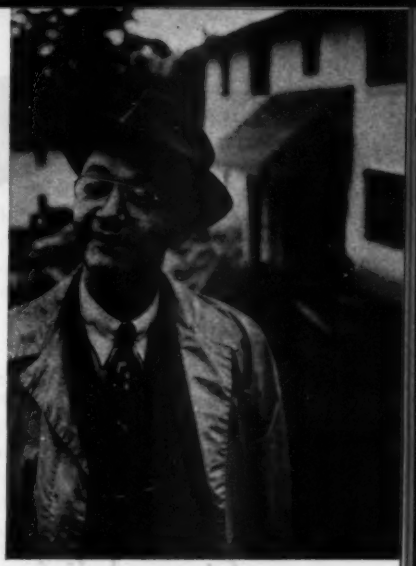
The father was a doctor of long standing in the town. His quarters weren't very modern, but neither were his patients, and you couldn't have pried them away. The son, on the other hand, was having a slow time getting started in his own office. When his father invited him in on an associate basis, it looked like quite a break.

Actually it was a bad mistake. The young doctor lost what patients he'd had; for his generation didn't take to the old-fashioned surroundings. And the father's patients still preferred him to his son. So the latter soon had to strike out on his own again.

Fail to make allowance for the kind of cases you handle.

Two Texans opened an accident clinic in a fast-growing industrial section. Everything pointed to success. But presently it became clear to the partners that they were doing less emergency work than M.D.'s much farther removed from the factory district. By picking a second-floor location, these two men learned the hard way that accident cases can't or won't climb stairs.

The case of a Maryland orthopedic surgeon is similar: He hung out his shingle in the downtown section of a prosperous, growing city; but his practice got nowhere. Reason: Most of his patients, be-



And Bring the Kids!

● Golden Rule landlord to 140 young, vet families—"kids, pets, music welcomed"—Surgeon Alfred A. Weinstein of Atlanta, Ga., keeps average rents under $50, discriminates only against hate mongers.

A vet himself (of Bataan and Jap P.O.W. camps), Dr. Weinstein got hopping mad when fellow vets were bilked in housing deals. Despite blocking tactics of real estate sharks, he built his new, no-gyp project with private and FHA funds. Nine out of ten tenants have children. He encourages new births (at $10 a head); has paid out on fifteen. Since proving that decent housing pays—even in money—he's deluged with how-did-you-do-it? letters.

New!

FER-IN-SOL

For the prevention and treatment of iron deficiency anemia

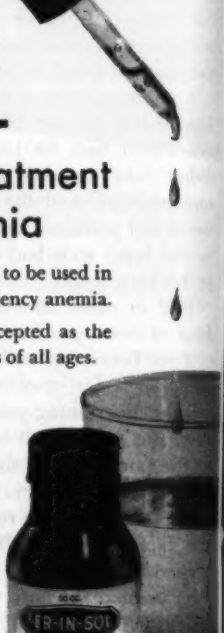
FER-IN-SOL is a concentrated solution of ferrous sulfate, to be used in drop dosage for prevention and treatment of iron deficiency anemia.

Ferrous sulfate in an acidulous vehicle is widely accepted as the most effective form of iron for administration to persons of all ages.

Because of its pleasant citrous flavor, Fer-In-Sol is taken willingly by infants and children. It blends perfectly with citrus fruit juices and leaves minimum aftertaste.

The Fer-In-Sol dropper is conveniently calibrated for doses of 0.3 and 0.6 cc. (7.5 mg. and 15 mg. of iron). Only 0.3 cc. is required to provide the Recommended Daily Allowance of iron for infants and young children; 0.6 cc. provides the Recommended Daily Allowance for adults, including pregnant women.

Available in 15 and 50 cc. bottles with appropriately calibrated dropper.



MEAD'S

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U. S. A.

ing incapacitated, could reach his office only by private automobile. The nearest place to park was a 75-cent lot three blocks away—which was just 75 cents and three blocks too much.

Overlook the virtues of your present location.

A California M.D.'s practice was the envy of most of his colleagues; his waiting room was invariably so full that some patients had to be seated in the hallway. When an outsize suite became available in an office building nearby, he snapped it up. Though the building itself was a bit seedy, he spent freely to make his office attractive. In both size and decor, it was unexcelled.

Yet from then on, the doctor's practice began to decline. No longer did his waiting room bespeak the much sought-after physician; even with ten or twelve people in it, it seemed empty. And, for all his modernizing, the doctor hadn't been able to do anything about the building as a whole. Shoddy-looking building employes, dingy corridors, and chain-clanking elevators probably alienated as many patients as the big, impersonal waiting room.

Spread yourself too thin.

A New York G.P. was doing well in a prosperous residential community. Eight miles away was another such community, rapidly growing. Why not double his practice, thought the doctor, by maintaining offices in both places?

All he doubled was his overhead. In both towns patients soon learned they couldn't rely on him to be around when needed; he lost more than he gained. Though certain specialists—dermatologists, for example—can often work the two-office stunt to advantage, G.P.'s who try it take a long chance.

Move too often.

A Florida practitioner first set up practice over a drug store. Eight months later he was offered an opportunity to share a small professional building with two other M.D.'s in one of the town's better residential sections. He promptly accepted. The following year he decided he'd rather lone-wolf it again, and took an attractive office two blocks away. But this was a little off the beaten track. Presently he found a nice spot near the shopping area.

By this time, however, he was

"But darling, Dr. Collins *loves* you!"

Psychoneurotic Women of Genius

Isadora Duncan, renowned American dancer, was admired throughout the world for her creative ideas and graceful artistry, but estranged her native public through her psychoneurotic eccentricities.

The majority of psychoneurotics have no serious mental illness, but display merely a emotional imbalance which often can be greatly improved by appropriate psychotherapeu and sedative management. In the treatment of psychoneurosis, particularly agitat depressed and anxiety states, Mebaral is especially useful when tranquillity with mini hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. (½ to 1½ grai three or four times daily. Children, from 16 to 32 mg. (¼ to ½ grain) three or four times dail Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

MEBARAL®

BRAND OF MEPHOBARBITAL

TASTELESS SEDATIVE AND ANTIEPILEPTIC • LITTLE OR NO DROWSINE

Winthrop-Stearns INC.

New York, N. Y. Windsor, Ont.

Mebaral, trademark reg. U. S. & C


NEW
The Best Bulk Laxative*
IN CAPSULE FORM
the Stuart
CMC
Capsules
Capsule form easier to take—capsule breaks down quickly;
unlike tablet, causes no feeling of sickliness in throat. Easier
than drinking gels.
Smaller dosage—2 capsules
Later, 1 or 2 capsules daily.
3 times daily at first.
More effective—Superiority
"in vitro" tests.
proved both
LOW IN COST TO PATIENTS
Available at
All Pharmacies
*"Evaluation of Hydrophilic Properties of
Bulk Laxatives, Including the New Agent,
Sodium Carboxymethylcellulose," Blyder,
Rudolph W., Goldrick, John L., and Tar-
bell, Harlen L., Scientific Edition, Journal
of American Pharmaceutical Association,
February, 1949.
the Stuart
CMC
Capsules
THE STUART COMPANY
the Stuart
Company

virtually without patients. None of his moves was a bad one, in itself. There were simply too many of them. People won't stick with a doctor who refuses to stay put.

Forsake your natural habitat.

A New England physician whose general practice was coming along nicely decided to close his residence-office in favor of a downtown medical building. There he would be in closer contact with specialists. He expected his practice would continue pretty much as it had before, with plenty of office calls, quite a few house calls.

The office calls developed, but not the house calls—much to his bafflement. Gradually it dawned on him that the patients he was seeing in his new location were not the kind who expected or even wanted house calls. He'd ceased to be a family doctor because he'd taken himself out of the proper environment for that kind of practice.

Another New England doctor strayed from his milieu in another, more personal way. An out-of-towner, he opened his office in the most fashionable suburb of a city known for its social clannishness. He was an able man, and everyone who met him said he was a nice enough fellow. But he just didn't belong. He probably could have made the grade if he'd had the resources to wait out the thaw. But he hadn't, so he soon had to move.

An Oregon doctor's case was cut from the same cloth. His specialty was an elective type of surgery, and he'd done quite well at it in a none-too-prosperous neighborhood. In a better-heeled community, he reasoned, he should do even better. But when he moved there, he just didn't go over. Here new patients were an entirely different class. He didn't seem to speak their language. So he finally moved back to the old stand. END

Thin Skinned

● The patient, a young Portuguese housewife, was suffering from a circumscribed neurodermatitis of the neck. When I told her it was of emotional origin, that she must be unhappy about something, her eyes filled with tears.

"Could be it's my husband, Doctor," she said, brokenly. "He's very mean man. All the time hit me, all the time scream at me. 'Get lost, you bastid,' he say. 'Go die, you bastid.'"

She wept softly for some moments, then looked up. "I don't know, though," she said, pensively. "Could be I'm too sensitive."

—M.D., HONOLULU

They Warn You Against Fire

These detectors and alarms help you thwart a blaze before it gets out of hand

● Discover a fire right after it starts and you've got a good chance of saving your office. But let it get a few minutes' headway and all the engines in town may not help.

To play safe, consider putting in automatic fire detectors. They're rigged to ring an alarm seconds after a fire breaks out.

Facts about the two main types of detector-alarms follow: Each warning device described is self-powered, requires no outside connection. Costs are for installation in an average size, three-room office.

Continuous-line thermostat. In the "Sidalarm Duplex," insulated copper tubing runs inconspicuously along the ceiling edge (where heat gathers). When temperature at any point along the tubing rises faster than 15 degrees a minute, the air in the tubing expands, trips an alarm bell that can be heard throughout the office. A second bell, that can be heard for a city block, may be placed outside a window.

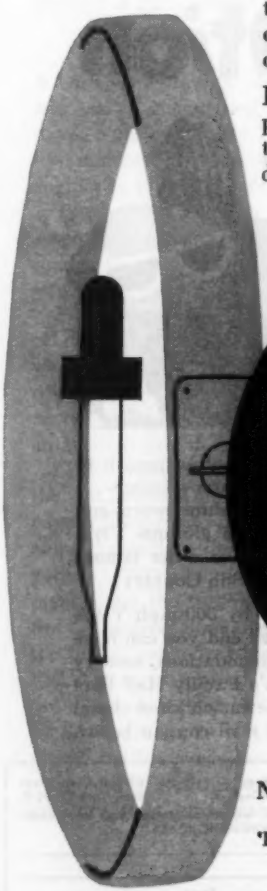
Since it is sensitive to quick temperature rises, this detector-alarm gives an early warning in case of a flash fire. Disadvantage: A slow-burning fire may get a fair start before temperature climbs at a fast enough rate to trip the alarm. To overcome this, the tubing will soon be made to ring an alarm when heat reaches 155 degrees as well as when it rises at more than 15 degrees a minute.

Once set off, the bells keep ringing until shut off by hand. No replacement of parts is necessary following an alarm. To test the system, you merely flick a switch. If a breakdown occurs, you are warned by a buzzer or a light. Cost: about $350.

"Protectowire," a heat-sensitive cable also attached to the ceiling edge, goes into action only when the temperature jumps above 155 degrees. While, like tubing, it gives even coverage throughout the office, it may not respond as quickly to a flash fire. At 155 degrees, insulation on the heated section of the cable softens, closing an electrical circuit that rings a six-inch bell. After an alarm, the softened part of the cable needs replacing (average fee for splicing in a new section: about $4). Cost of the system, with a second bell for outside installation, is about $150. [*Turn page*]

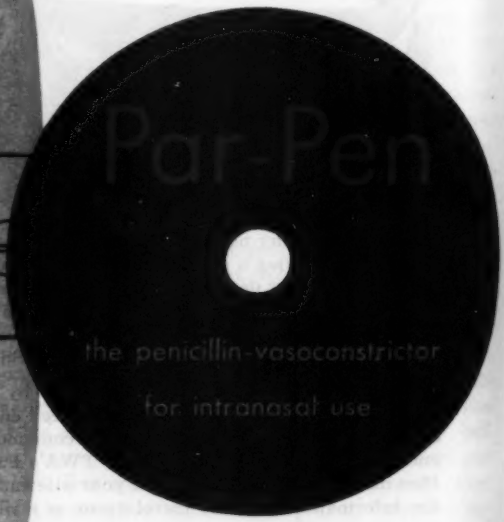
"Of all the medications tried for treatment of the common cold during my thirteen years as Chief of Otolaryngology at this school*, [Par-Pen] has proved the most satisfactory."

Furlong, T.F., Jr.: Clinical Test of a New Spray, Arch. Otolaryng. 48:658.
**The Pennsylvania School for the Deaf, Philadelphia*



Potent Bacteriostasis Par-Pen provides the potent antibacterial action of 5000 units of penicillin per cc. . . . plus the vasoconstriction of 'Paredrine' Hydrobromide, 1%.

Deep Penetration Penicillin in solution penetrates the tissues more readily than the sulfonamides or tyrothricin, reaching deeply embedded organisms.



Now packaged in convenient ½ fl. oz. bottles.

'Paredrine' & 'Par-Pen' T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

Spot thermostats. Devices like "Fire Detective" and "Fire Control" depend on several thermostats the size of a cigarette package. These are placed near the ceiling and go into action when temperature near one (1) climbs faster than 15 degrees a minute or (2) reaches 165 degrees. One thermostat is usually enough for a room up to thirty feet square. Since this thermostat occupies a smaller area than the continuous-line type, it's not likely to detect fires so fast.

When the alarm is set off by heat reaching 165 degrees, the thermostat must be replaced (cost $5). No replacement is needed, however, if the alarm is caused by a rapid rise in temperature. Frequent testing, by means of a push-button on the control box, is necessary because there is no warning signal if the wiring breaks. Cost: about $100.

Minimum protection can be had with other spot thermostats, such as "Fyr-Cry," a compact, self-contained unit about the size of a cigar box. At 137 degrees, a wax fuse melts, setting off a clocklike mechanism that sounds an eight-inch gong.

After an alarm, the fuse has to be replaced and the alarm spring rewound. (Cost of new fuse: 65c.) You need one unit in every room and closet. Since there's no automatic signal to warn of a faulty mechanism, each alarm should be tested at least once a month. Cost: $15 per unit, or $75 for a three-room suite with two closets. END

"The doctor told me I have the biggest pair of tonsils he ever saw."

Within 15 Minutes of the*

FIRST SNEEZE

SYNTHENATE TARTRATE usually produces gratifying, often dramatic results, when employed in the early phase of coryza.

*In 65% of cases complete remission of symptoms occurs within fifteen minutes after injection of 1 cc SYNTHENATE TARTRATE-Breon, when administered within twenty-four hours of the first sign of a cold!

Injection is simple . . . relatively nontoxic . . . prolonged in effect. SYNTHENATE TARTRATE-Breon increases cardiac efficiency and frequently slows the pulse rate; thus it is effective without appreciably increasing the work of the heart. It does not cause cardiac arrhythmias, does not stimulate the central nervous system, does not produce signs of anxiety.

Simplicity of Administration: 1 cc is injected intramuscularly or subcutaneously . . . repeated in 3 or 4 hours, if required.

Available at all drug stores.
1 cc ampuls — boxes of 12 and 25.

Complete literature to physicians on request.

George A. Breon & Company
Pharmaceutical Chemists NEW YORK 16, N.Y.

BREON

for infants and children, and adults

who prefer liquid iron medication

Feosol Elixir is eagerly accepted **because it is so highly palatable. (When prescribed for infants and children, it should be given with water, fruit or vegetable juices.)**

. . . is easily tolerated **because it contains ferrous sulfate, the iron salt least likely to cause gastro-intestinal upset.**

. . . is highly effective **because ferrous sulfate is the most readily assimilated form of oral iron.**

Each 2 fluid drams (2 teaspoonfuls) supplies 5 grains ferrous sulfate—the approximate equivalent of 1 Feosol tablet.

Smith, Kline & French Laboratories, Philadelphia

'Feosol' T.M. Reg. U.S. Pat. Off.

liquid iron

Income Tax Problem Clinic

Answers to questions that M.D.'s are asking about their Federal returns

● QUESTION: *Suppose I discover an error in my final tax return after it has already been filed? What should I do?*

ANSWER: File an amended return, using the same form (1040), and state clearly the reason for the change. If the change results in a lower tax, it is advisable to attach the amended return to Form 843, "Claim for Refund."

QUESTION: *Can I use estimated figures for income or expenses on my tax form?*

ANSWER: Yes, if you don't do it to excess. But if there's any way of getting exact figures, use them. The burden of proof for even reasonable estimates is on the taxpayer.

QUESTION: *Am I permitted to deduct long-overdue medical fees as bad debts?*

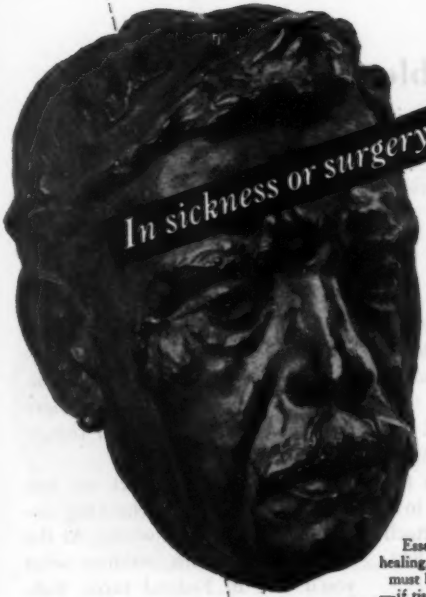
ANSWER: Since most medical men make up their tax returns on the basis of cash received and expended, unpaid fees may not ordinarily be deducted. Reason: They were not reported as taxable income in the first place.

QUESTION: *It's hard for me to maintain a large enough bank balance to meet my estimated quarterly tax payments. A good-sized balance is a temptation to divert more cash than I should to other things. Any suggestions?*

ANSWER: Some doctors use two checkbooks for one checking account. Here's how it works: At the end of each month, estimate what you'll owe in Federal taxes. Subtract the estimate from the first book, with a notation saying, "Transferred to Tax Savings Checkbook." Then enter the amount in the second checkbook. When the due date of your estimated quarterly tax payment arrives in the third month, the balance in your tax savings checkbook should about equal what you owe. So you draw a check against that balance.

QUESTION: *Should I now withhold for social security tax purposes*

**Do you have a tax problem that's of general interest? Questions are answered here, as space permits, by* *Alfred J. Cronin, of Murphy, Lanier & Quinn, New York, accountants and tax consultants.*



In sickness or surgery, play safer with . . .

"Saturation Dosage"

of vitamins b *and* c

Depletion of the critical water-soluble B complex and C vitamins occurs so commonly in the presence of physical pathology, as to make a presumption of nutritive impairment[2] almost axiomatic. Essential to normal cell metabolism and wound healing, these poorly-stored, readily-diffusible factors must be replenished — usually by *massive dosage* —if tissue rehabilitation[3] and return to health[4] are to be expedited. • Allbee with C 'Robins' provides this all-important "saturation dosage" in convenient capsule form. It incorporates the important B factors in 2 to 15 times daily requirements, plus 250 mg. of vitamin C — *the highest strength of ascorbic acid available today in a multi-vitamin capsule.* • Its prescription represents a sound contribution toward decisive recovery from disease, or toward pre- and post-operative nutritional support.[1]

A. H. ROBINS CO., INC. • RICHMOND 20, VA.

Ethical Pharmaceuticals of Merit since 1878

FORMULA: *Each Allbee with C capsule contains:*

Thiamine hydrochloride (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Nicotinamide	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (C)	250 mg.

REFERENCES: 1. Collier, F. A. and DeWeese, M. S.: Preoperative and Postoperative Care, J.A.M.A., 141:641, 1949. 2. Jolliffe, N. and Smith, J. J.: Med. Clin. North America, 27:547, 1943. 3. Kruse, H. D.: Proc. Conf. Convalescent Care, New York Acad. Med., 1940.
4. Spies, T. D.: Med. Clin. North America, 27:273, 1943.

allbee® WITH C

Robins

part of the wages of household servants and farm employes?

ANSWER: Starting Jan. 1, 1951, you must withhold from every such person who (1) earns $50 or more during any calendar quarter of the year and (2) is employed at least twenty-four days (sixty days for a regularly employed farm worker) during that quarter or the preceding quarter. You have to report the people's names and the amount of tax on each quarterly return. You do *not* have to withhold income tax on domestics. Only the social security deduction is required.

QUESTION: *Does my wife, solely employed as my secretary, come under the provisions of the revised Social Security Act?*

ANSWER: No. The part of the old law that excludes the spouse and children (under 21) of an employer is still in force. Nor can your wife qualify under the new law as self-employed.

QUESTION: *How can I determine the life span of a piece of furniture or equipment for use in computing depreciation?*

ANSWER: Your best bet is to get an estimate from the manufacturer. But you're usually safe in figuring the life of furniture as ten years; a car, four years; an X-ray machine, eight years. —ALFRED J. CRONIN

Pass the Corn, Please

By Roy Eastman

● Corn is perhaps the most American thing in America. It is the emblem of prosperity, the symbol of liberty and strength. It is the most beloved of all the grains, if not indeed of all the foods that are garnered from the earth. It is bounteous and heartening in all its phases: The succulent kernels of the unripened sweet corn are charged with the sweetness and promise of abounding youth. The golden grains of the ripened and seasoned field corn fulfill that promise. The very word itself is American, for in other countries corn is called "maize."

There's a singular appropriateness, then, in the way the supercilious critic of all things homely, familiar, and earthy has seized upon the word "corn" or the derivative "corny" to label them.

It's a good label. Let it stick. I'll take the corn and you can have the orchids. [*Turn page*]

RHEUMATIC CASES OF

FOUND

OUTSTANDING RELIEF

Cross-section of knee joint. Red area denotes synovial membrane wherein attributed action of sodium gentisate against hyaluronidase occurs.

Clinical work now being carried on with GENTARTH on arthritic patients, some of whom have been suffering for 30 to 35 years, reveals that this new Raymer formula gave relief beyond that ever experienced with any previous drug. *Not a single case of intolerance has been reported.* Furthermore, toxicologic reports indicate that on a weight-for-weight basis, GENTARTH is less toxic than aspirin.

GENTARTH *contains in each salol-coated tablet:*

Sodium Gentisate	*100 mg.*
Raysal	*325 mg.*
(representing 43% Salicylic Acid and 3% Iodine in a Calcium-Sodium Phosphate Buffer Salt Combination)	
Succinic Acid	*130 mg.*

Recommended dosage:
2 or more tablets, 3 or 4 times daily (after meals and before bedtime)

Available at all pharmacies on prescription

Nearly a Third of a Century Serving the Physician

PHARMACAL COMPANY

Pharmaceutical Manufacturers • Philadelphia 34, Pa.

Pioneer Producers of Gentisate Medication for the Medical Profession

30-35 YEARS' STANDING

WITH GENTARTH

The New Gentisate-Containing Anti-rheumatic

GENTARTH INHIBITS SPREAD OF HYALURONIDASE

While the basis of GENTARTH is buffered salicylate, still the accepted stand-by in the arthritides, to it has been added sodium gentisate which Meyer and Ragan[1] have shown to bring favorable results in rheumatoid arthritis and acute rheumatic fever. Pain, swelling and joint inflammation disappeared. The action of sodium gentisate has been attributed to its inhibition of the spreading effect of hyaluronidase.[2,3] *Raymer has pioneered in making sodium gentisate available to the medical profession.* Succinic acid, also present, protects against decrease in prothrombin time, a necessary precaution in continued salicylate therapy.

GENTARTH *Tablets are supplied in bottles of 100, 500, 1,000.*
Also Available Sodium Gentisate Tablets 325 mg.—bottles of 100. Sodium Gentisate (powder) for prescription formulation through leading pharmacies.

[1] Meyer, K. & Ragan, C.: Mod. Concepts of Card. Disp., 17:2 (1948)
[2] Quick, A. J.: J. Biol. Chem., 101:475 (1933)
[3] Guerra, J.: J. Pharm. Exp. Ther., 87:1943 (1946)

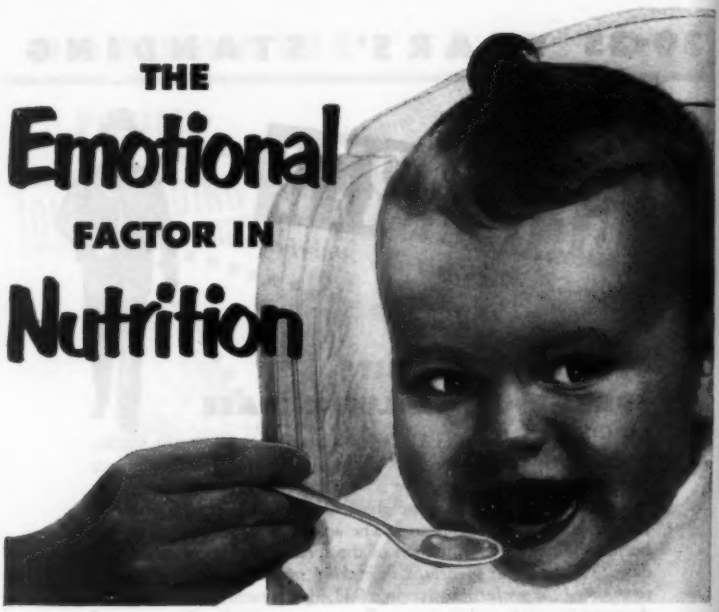
NEW CLINICAL EVIDENCE

Since the first appearance of this advertisement, new clinical evidence on GENTARTH establishes 30% greater effectiveness than salicylate alone. For other last minute reports on sodium gentisate, see

Camelin, et al: Presse Medicale, 58:889 (1950)
Schaefer, et al: Circulation, 2:265 (1950)

Your request on a prescription form will bring a free clinical supply of GENTARTH, ample to demonstrate its efficacy—enough for 1 case for 1 week—and descriptive literature!

THE Emotional FACTOR IN Nutrition



A BABY's relationship with his mother can influence his assimilation of food—for good—or ill!

When a worried mother asks you how to "make" her baby eat more, help her understand that a baby can't get full benefit from his meals unless he *enjoys* his food.

One of the biggest things a mother can do for her baby is to avoid mealtime arguments. Beech-Nut Foods in all their appealing variety are a great help. Their better flavor arouses *eager* appetite. Baby gets a *good start* nutritionally and emotionally!

A wide variety for you to recommend: Meat and Vegetable Soups, Vegetables, Fruits, Desserts—Cereal Food and *Strained* Oatmeal.

All Beech-Nut standards of production and advertising have been accepted by the Council on Foods and Nutrition of the American Medical Association.

Beech-Nut FOODS *for* BABIES

Babies love them...thrive on them!

A man speaks feelingly on a subject that is close to his heart, or gives a word of comfort or sympathy to a friend who needs it. He flicks the suspicion of a tear from the corner of his eye and murmurs a half apology, "That's corny I know."

Sure it is. But it's nourishing too, and people are the better for it. Why must we always button up our hearts beneath asbestos vests?

Men work with heart, head, and hands; but the labor of the head and hands alone is fruitless. Put more heart in your work and let the head and the hands do the heart's bidding. Then your works will flourish.

Let It Ripen

You doctors: How many times have you felt a surge of warm feeling for your wife, for a patient, for a friend, and wanted to express it with your eyes glistening and a tingle in your blood? And how many times have you quashed that urge and left the words buried in your heart? "Corny," you said to yourself, and perhaps left the other person hungry for the corn that never ripened.

People *like* corn, as long as it has kernels they can sink their teeth into.

The world is languishing for men and women in all walks of life who will speak and act from the heart rather than from the head alone. For these the rewards are abundant: The greatest of all is to be loved by your fellow men.

I am moved to this discourse by a letter that the secretary of a business executive received from one of the company's field staff. The letter said:

On Second Thought . . .

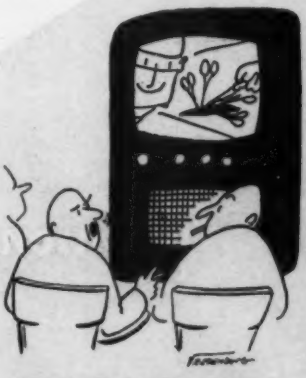
"It was four years last September that you sent me my first assignment. I was scared to death.

"You never knew how your little notes pepped me up. I used to look forward to the notations you added to the instructions. And how I wished I had your sense of humor!

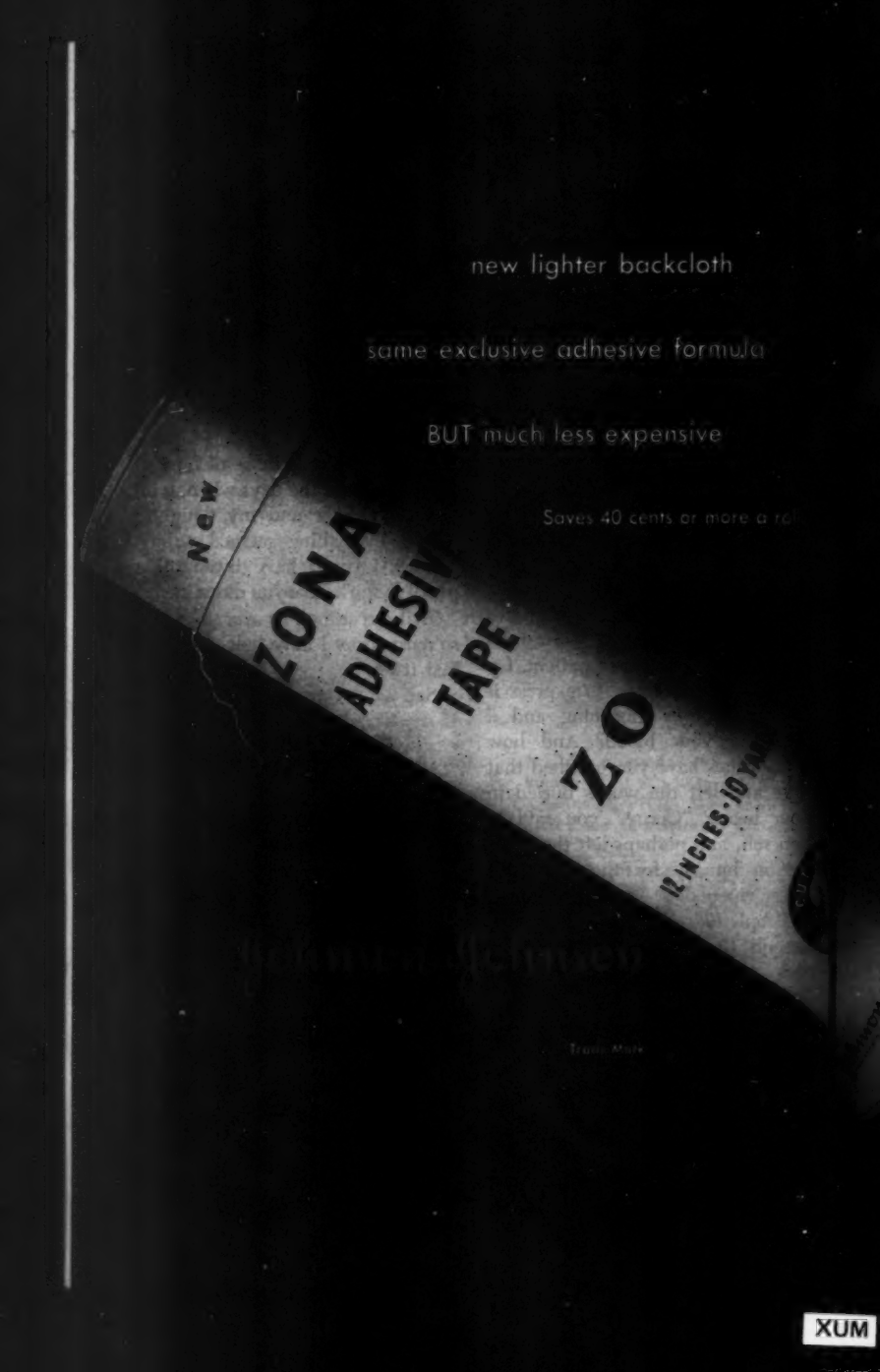
"Those were the days when, with my son at war and my daughter failing, everything seemed wrong. If only I could have lifted other people's spirits like you did mine . . .

"After reading this over, it sounds so darn corny I have half a mind to tear it up."

See what I mean? END



"That's Beson for you—always upstage."


new lighter backcloth
same exclusive adhesive formula
BUT much less expensive
Saves 40 cents or more a roll
New
ZONA
ADHESIVE
TAPE
ZO
12 INCHES · 10 YA
XUM


onas*
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dhesive
avings
XUM

DOUBLY EFFECTIVE

in acute upper respiratory infections

In the treatment of chronic sinusitis and the acute sinus complications of coryza, Bacitracin-Nasal affords a dual approach.

It supplies bacitracin, effective against many gram-positive pathogens which inhabit the nose and accessory nasal sinuses.[1] Administered by spray or by aerosol inhalation, a solution of bacitracin has been reported to reduce the severity and duration of sinus infections.[2,3]

The presence of desoxyephedrine in Bacitracin-Nasal aids in improving nasal ventilation and reduces patient discomfort for prolonged periods.

Reconstituted by the pharmacist just prior to being dispensed, Bacitracin-Nasal contains bacitracin, 250 units per cc., and 0.25% desoxyephedrine in an approximately isotonic, rose-scented aqueous vehicle. It is available on prescription at all pharmacies in 15 cc. bottles together with dropper.

1. Prigal, S. J.: Bacteriologic and Epidemiologic Approach to the Treatment of Respiratory Infections with Aerosols of Specific Antibiotics, Bull. N. Y. Acad. Med. 26:282 (Apr.) 1950.

2. Stovin, J. S.: The Use of Bacitracin in the Treatment of Sinusitis and Related Upper Respiratory Infections, New York Physician 32:14 (July) 1949.

3. Prigal, S. J., and Furman, M. L.: The Use of Bacitracin, a New Antibiotic, in Aerosol Form; Preliminary Observations, Ann. Allergy 7:662 (Sept.-Oct.) 1949.

C.S.C. Pharmaceuticals

A DIVISION OF COMMERCIAL SOLVENTS CORPORATION • 17E. 42nd ST., NEW YORK 17, N.Y.

Show Them What They're Paying For

[*Continued from* 59]

that 'professional services' line. We'd *know* we were being overcharged."

Grumbling like this may never reach your ears—unless you're in the habit of hiding under canasta tables. But you can be sure it takes place.

Jane, my office assistant, sensed the problem before I did.

She was talking with an executive about a compensation report I had submitted. The claim listed office calls, house calls, X-rays, and operative procedures—each with a stipulated fee.

"Look," griped the executive, who happened to be one of my patients, "you itemize everything when you do business with the insurance company. But for duffers like me it's a hundred bucks with no explanation. How come?"

Jane relayed the remark to me, along with a first-rate idea.

"Patients who come here," she said, "are apt to kick if a bill runs over $25. But they'll pay a hundred or two at the Fanfare Clinic and not think a thing of it.

"We give the same exams and tests here that they give at Fanfare. But people don't realize it. Nor does it work just to *tell* them what a charge is for. I've tried that. To most patients PSP, BMR, and ECG are just alphabet soup unless they're spelled out.

"What *I* think we need is a slip with all the tests and things on it—a slip we could give patients, so they'd know what they were paying for. They'd like it a lot better—and we'd get fewer dirty looks."

So we made up what we now call a "service slip" [*see cut*]. It has lines for office calls, physical ex-

ORVILLE S. WALTERS, M. D.
216 GRAND BUILDING • McPHERSON, KANSAS

Name_____

Date_____

Office Visit		
Physical Examination		
Medication		
Urinalysis		
Blood Count, White Cells		
Blood Count, Red Cells		
Blood Count, Differential		
Hemoglobin		
Sedimentation Rate		
Electrocardiogram		
Electrocardiograph Exercise Test		
Basal Metabolism		
Gastric Analysis		
Blood Sugar		
Kidney Function Test		
Blood Test		
Skin Test		
Office Surgery		
X-Ray		
Total		

amination, and medication. In addition, it lists all common diagnostic procedures and provides extra blanks for writing in less common charges. The slip is filled out after a visit or series of visits when the patient ordinarily expects his bill.

When the patient asks for a monthly statement instead of paying cash, the itemized slip goes along with the statement. (I don't use the slip for hospital or house calls. These are shown separately on my monthly statements.)

How Patients Liked It

Jane pronounced the slip a success after a single day's trial. She reported typical reactions:

¶ Hank, the hardware man, walked out studying the slip. "What next?" he said, grinning. "First time *I* ever got an itemized bill from a doctor."

¶ Mrs. Walworth went over each item, then commented on the "thorough checkup" she had gotten.

¶ Jim Osborne noted the line "Metabolism Test," said he didn't know we had a machine. He made an appointment.

Today, after only three months, Jane finds her idea being copied. "You know the old saw about imitation being the sincerest form of flattery," she remarked recently. "Well, Mrs. Wilson told me that she and her sister had been comparing bills for their operations. And what do you know? Fanfare Clinic is now using a service slip just like ours."

—ORVILLE S. WALTERS, M.D.

ELIMINATE

STAGNANT AIR!

AIRBORNE BACTERIA!

UNPLEASANT ODORS!

with

SANITIZAIRE
Ultraviolet
ODOR ELIMINATION . . . AIR DISINFECTION

in your

WAITING ROOMS
OPERATING ROOMS
CONSULTATION ROOMS

Sanitizaire provides the profession with the nearest and best solution to odor and bacterial problems. Foul odors are eliminated. Airborne bacteria is substantially reduced. The air is kept clean and sweet. Sanitizaire is constantly effective.

Portable – may be placed wherever there is an electrical outlet. Safe – no burns from rays. Silent – does not disturb patients. Guaranteed lamp life of 10,000 hours, which equals 14 months of constant use, 24 hours a day. Low operating cost – from ¼ to ½ cents an hour. Los Angeles seal of approval. Write for documented private laboratory tests.

sole distributor:

EVEREST & JENNINGS

761 N. Highland Ave., Los Angeles 38, Calif.

New Power at The Polls

[*Continued from* 78]

2. Carroll vs. Millikin in Colorado. At first, compulsory health insurance wasn't a campaign issue here. But it soon worked its way in. Three weeks before the election, a statewide poll by Research Services, Inc. showed the Democrats with 54 per cent of the vote. The party's candidate for the U.S. Senate, John A. Carroll, leaned in the direction of the Ewing plan. Most physicians leaned in the direction of the opposition candidate, Senator Eugene D. Millikin. But they hadn't done much about it.

With twenty-one days to go, the doctors came to life. They didn't bother with formal organization. They simply closed each professional visit with a direct question—"Are you registered to vote?"—followed by a couple of minutes' low-pressure discussion. And they wrote personal letters—12,000 in one Northern Colorado county alone. Pediatricians even devised a special missive of their own: "It is my personal conviction that we must act now to protect the future of our children . . . May I urge you to support Senator Millikin in this campaign."

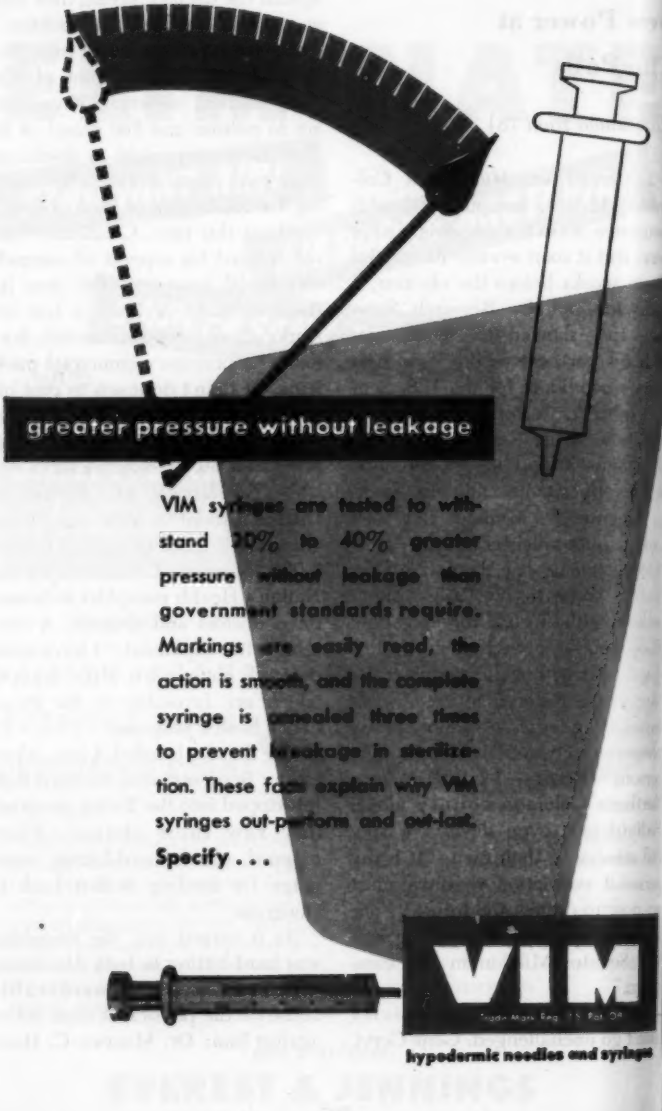
This flurry of medical activity didn't go unchallenged. Gene Cervi, a Denver editor, launched a tirade against the doctors, saying they had no right to "mix pills and politics." This drew a prompt retort from Dr. Ervin A. Hinds, president of the state medical society: "Physicians are in politics and I'm proud of it. They have every right to discharge their civic responsibilities by working for candidates of their choice."

About this time, Candidate Carroll hedged his support of compulsory health insurance. But since he simultaneously dropped a few remarks about "dollar-conscious doctors who practice commercial medicine," it didn't do much to cool off his opposition. Physicians sparked the late surge that brought Senator Millikin a 30,000-vote victory.

3. O'Sullivan vs. Buffett in Omaha. About a year ago, Congressman Eugene O'Sullivan mailed 5,000 copies of a Committee for the Nation's Health pamphlet to hometown doctors and dentists. A covering letter explained: "I have some decided notions on this matter which are favorable to the President's health program . . ."

The doctors bristled. Later, when former Representative Howard Buffett ripped into the Ewing program, they saw their chance. They mapped out a hard-hitting campaign for sending Buffett back to Congress.

As it turned out, the campaign was hard-hitting in both directions. O'Sullivan heaped considerable abuse on the physicians most active against him: Dr. Maurice C. How-


greater pressure without leakage
VIM syringes are tested to withstand 20% to 40% greater pressure without leakage than government standards require. Markings are easily read, the action is smooth, and the complete syringe is annealed three times to prevent breakage in sterilization. These facts explain why VIM syringes out-perform and out-last.
Specify . . .
VIM
hypodermic needles and syringes

ard, a Democrat who headed the healing arts committee, and Dr. J. Phil Redgwick, his first lieutenant.

And when Omaha medical men began slapping anti-O'Sullivan stickers on the bills sent to patients, they were paid back in kind. AFL members attached labels to their letters reading: "Through the efforts of Congressman O'Sullivan, I am better able to pay on this account."

But physicians had more effective tricks up their white duck sleeves. In every Omaha hospital, for example, patients were dealt out notices like these: "We are sorry you have to be ill but . . . we are happy that you chose this hospital. If you prize the privilege of choosing your own doctor and hospital . . . go to the polls on November 7 and vote for those who are opposed to politically controlled medicine."

For five weeks, the healing arts committee ran a high-velocity campaign. It hired an office, an executive secretary, an advertising agency. It bought radio time and newspaper space. It devised special appeals to racial and nationality groups. Meanwhile, doctors broached the health insurance issue with each patient they treated. And doctors' wives worked quiet miracles of influencing their friends.

All of which made health insurance the prime election issue. Other matters—ranging from Korea to a $10 million municipal bond issue—were submerged. Said Dr. Redgwick shortly before E-Day: "Socialized medicine has become so much a part of this campaign that some persons probably expect to find a socialized medicine proposal on the ballot. Of course, it won't be there. But you will find the name of Howard Buffett on the ballot, and there's no question of how he stands on this important issue."

By now, Congressman O'Sullivan was thoroughly alarmed. He put out a statement saying, "I am now and have always been against socialized medicine. There is no bill pending in either the Senate or the House creating socialized medicine." When this didn't take, Labor's League for Political Education sponsored a large O'Sullivan ad—the day before elections—announcing that their candidate was "against socialized medicine and against compulsory health insurance."

The backtracking came too late. Buffett piled up a near-record total of 70,000 votes, to O'Sullivan's 40,000. Two years earlier, O'Sullivan

had been the winner by 3,000 votes. Said nearly all political observers, in effect: "This time the doctors made the difference."

4. Douglas vs. Nixon in California. Here the health insurance issue was somewhat subdued. But Helen Gahagan Douglas was of the Ewing stripe, Richard M. Nixon definitely was not. So the doctors trained their letter-writing techniques on the campaign for U.S. Senator.

These techniques were polished to a higher gloss than anywhere else in the U.S. California doctors have long written campaign letters to patients. They've had to. Under the guidance of Ben H. Read, executive secretary of California's Public Health League, they've evolved three tested principles: (1) Make the letters short and to the point; (2) sign them by hand; (3) mail them in your own professional envelopes, with no enclosures.

This time, forty-four physicians got things rolling. They comprised the entire medical roster of Whittier, Calif.—Richard Nixon's home town. They fired off notes to every licensed physician in the state, asking financial help and letter-writing aid.

They got plenty of both. So, before long, some 200,000 letters went winging toward patients. They said, in effect, that Richard Nixon was eminently qualified; that he had a sound voting record on affairs of the day; and that the recipient's vote was solicited. No mention of Communism or compulsory health insurance. Just a simple request for a vote.

Nixon won handily over Helen Douglas. The doctors earned credit for an assist. When the newly elected Senator was asked to name the Administration's domestic mistakes, he told his radio audience: "Socialized medicine!" It was—understandably—the first thing that came into his mind.

5. Lucas vs. Dirksen in Illinois. After talking with the candidates, an interprofessional committee in Chicago reported: "Senator Lucas' opposition to socialized medicine, and especially to compulsory sickness insurance, has appeared only since the healing arts began to organize politically. He should be defeated as the symbol of the pro-Socialist trend in Washington."

Senator Lucas lashed back. The doctors were "perpetrating a fraud on the people," he cried. "I have been opposed to socialized medicine since 1938." What's more, he added, a number of physicians—

"I'm *sure* I have my stethoscope in here somewhere."

headed by Dr. Edward L. Compere of Chicago—were working for him.

But the Dirksen doctors had the edge. To raise funds, they got their wives to give a series of progressive teas. They peppered Chicago with 100,000 leaflets. They pasted pro-Dirksen labels on medicine bottles, ran ads in local papers. And downstate—in Effingham and Christian counties, for example—they printed large placards for waiting-room display: "In protest to the threat of socialized medicine, the offices of physicians and dentists in this county will be closed on election day. Vote for Everett M. Dirksen for U.S. Senator."

These maneuvers, said some critics, smacked of "tantrum tactics." But most voters didn't see it that way. Of thirty-eight candidates endorsed by the interprofessional committee, thirty-four (including Dirksen) won election. Said John J. Hogan, the committe's general consel: "This proves that the welfare of the professions, as well as the welfare of all our citizens, can be determined by the ballot."

6. *Campbell vs. Capehart in Indiana.* Alex M. Campbell had been a member of the Truman Administration's "Little Cabinet." He returned from Washington to run for Senator on a straight Fair Deal platform, the health plank included. So the doctors swung into action.

They collected all the Congressional candidates' views on health, published them verbatim in a pocket-size booklet, then saw that every civic leader received a copy. They asked for resolutions against compulsory health insurance—and got them from 2,055 Indiana organizations. They uncorked a $60,000 ad campaign.

In Lake County and in South Bend, doctors were organized in teams, assigned territories for getting voters to the polls. In Vanderburgh County, medical men ground out more than 10,000 personal letters. In Madison County, it was announced: "Only emergency cases will be attended on election day."

Senator Capehart challenged the opposition to a series of "Lincoln-Douglas debates"—health insurance to be included. Candidate Campbell shied off, so Representative Andrew Jacobs stepped into the breach.

The aftermath? Both Campbell and Jacobs were beaten at the polls. Says one Indianapolis observer: "Political leaders in this state are still dazed by the power and effectiveness of the doctors' campaign."

7. *Fairchild vs. Wiley in Wisconsin.* This Senatorial race pitted Thomas E. Fairchild, 38, against Alexander Wiley, the incumbent. Two years ago, when Fairchild was elected State Attorney General, he piled up the largest vote ever cast for a Democrat in Wisconsin. But when he embraced compulsory health insurance, the storm broke.

As a matter of fact, it broke squarely over the heads of the state medical society. At their annual session in October, the doctors invited

candidates from both parties to air their views. Fairchild was among those accepting. He plumped strongly for the Ewing plan as "a democratic extension of the great American principle of insurance."

Wiley was represented by a substitute, who promptly lit into the Ewing plan. While he was speaking, Fairchild passed a note up to Dr. J. W. Truitt, forum chairman. Was the substitute presenting a statement from Wiley? If not, wasn't he violating the forum rules?

The forum dissolved in an uproar. Next day, the doctors voiced some opinions of their own: "Candidates [such as] Thomas E. Fairchild make it clear that the proud American Way of voluntary systems, free from compulsion, will be destroyed in this country if their views are to prevail . . . The fight is on."

Medical men pressed their fight by letters, by radio platters, by circulars, by newspaper ads. The health issue was clearly drawn; it proved Fairchild's undoing. He lost by the margin of the medical vote.

8. Ferguson vs. Taft in Ohio. Health insurance was a side issue in this widely publicized Senatorial contest. But it still figured prominently enough to make 98 per cent of Ohio physicians cast their ballots. Registration records were set with the help of paid field workers, block captains, and a whole army of volunteer canvassers—many of them from medical families.

Healing arts committees arranged

personal interviews with all candidates. Joseph T. Ferguson, they discovered, had kind words for the Ewing plan. That was all the doctors needed to know.

They organized local committees to contact shut-ins and invalids, aid them in casting sick voter's ballots. They hired poll watchers for election day—people who would check lists of Taft-disposed voters, phone those who hadn't appeared by noon.

Thus Ohio medicine added its bit to the Taft landslide. Said the state medical journal in a post-election editorial: "The tactics [the doctors] used were neither new nor original . . . Their real achievement was that they rolled up their sleeves and went to work—many of them for the first time."

9. Cavalcante vs. Sittler in Western Pennsylvania. While Dr. Howard Conn's leaflet-dropping mission rated the headlines here, it was far from the whole show. Representative Anthony Cavalcante openly supported the Ewing plan; Edward Sittler vigorously opposed it. The

doctors rallied to Sittler's side. Under the leadership of Drs. William C. Murphey, Regis Maher, and Ralph L. Cox, they got surprising results on a shoestring budget ($3,-800).

Via airwaves, headlines, and word of mouth, they took their case to the people. Health insurance became the top issue—so much so that Cavalcante spent most of his radio time answering the healing arts group.

Only once in twenty years had the district sent a Republican to Congress. This month Ed Sittler becomes exception No. 2—thanks in large part to the doctors.

He Called the Turn

It was only two years ago that an earnest young Congressman found it necessary to write a drastic-sounding Rx for America's physicians. Said Representative Forest A. Harness in late 1948: "Medicine's problems are not going to be solved at the academic level. If you hope to survive as practitioners of a free and untrammeled science, you must, in my opinion, become practicing politicians. If you continue as academicians, I frankly fear that you will soon practice as a medical bureau in Washington directs."

Private medicine isn't yet off the danger list. But its new-found power at the polls dims the likelihood that American physicians will "soon practice as a medical bureau in Washington directs."

—R. CRAGIN LEWIS

In TRICHOMONIASIS consider these advantages of

ARGYPULVIS

1. *Outstanding effectiveness*... (98% as reported by Reich, Button and Nechtow).*

2. Its detergent and demulcent actions... (adapting to this specialized field the outstanding properties of ARGYROL).

3. Its chemical *and* physical characteristics... (which make it ideal both for office insufflation and home capsule use).

Adopt the ARGYPULVIS technique and note the quick response to treatment, as well as effective control of recurrence.

....in two convenient forms

For Use by the Physician. 7-gram bottles fitting Holmspray or equivalent powder-blower (in cartons of 3).

For Home Use by the Patient. 2-gram capsule for insertion by the patient (in bottles of 12).

INTRODUCTORY TO PHYSICIANS: *On request we will send professional samples of ARGYPULVIS (both forms), together with a reprint of the Reich, Button and Nechtow report. (Use coupon.)

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The Newsvane

Britons Cooling Toward NHS Medical Care

Britons have mixed feelings about medical care under the National Health Service. In a recent survey by the British Institute of Public Opinion, here's how they compared NHS care with private care:

Worse	21%
Better	14
About the same	48
No opinion	5
Haven't used NHS	12

This reflects less enthusiasm for the NHS than was shown by a similar survey in 1949.

Wants Private M.D.'s to Care for Soldiers

Congress is mulling over a plan that would place medical care of much of the armed forces in the hands of private doctors. The latter would be free to care for private patients, too, under the program.

Dr. D. W. Kingsley of Hastings, Neb., author of the plan, says it's wasteful to use a large number of service physicians within the continental U.S. Instead, he'd have county medical societies or other medical groups operate the medical facilities at military bases. All doctors capable of working would be used.

"A physician with an artificial limb, hernia, or impaired eyesight," says Dr. Kingsley, "should not be rejected if he is capable of performing efficient professional services." He estimates his plan would cut the number of service M.D.'s by as much as 50 per cent "yet maintain a high quality of service."

CPA Warns Medical Men Against Tax Miscues

Many M.D.'s are "appallingly naive" about keeping financial records, reports Walter J. Schneider, partner of the Manhattan CPA firm of Klausner and Schneider. He's found that doctors are often charged with income-tax deficiencies simply because they can't prove deductions—or sometimes even income.

He cites the case of a well-known specialist: "He gave a lot of his time to charity work, and his net income was actually under $5,000. But I had a terrific time proving it to a Treasury Department agent. Treasury men assume that, because medical men as a group rank in the upper-middle income brackets, they *all* make big money."

This causes trouble when a doc-

tor's records aren't adequate, Mr. Schneider points out. "In such cases," he says, "the Treasury Department prepares a net worth statement, then taxes the doctor on that basis. It's in cases like these that tax deficiencies really mount up."

How to keep records that will satisfy the T-men? Mr. Schneider offers these pointers:

¶ Whenever you accept cash payment, issue a receipt from a prenumbered receipt book. Then mark the number of the receipt on the patient's medical card. Thus you've got a lasting record of what you've charged each patient.

¶ When preparing a bank deposit, add up the receipt stubs and make the deposit for exactly that amount. (Bank deposits from sources not covered in the receipt book should be noted for separate reference.)

¶ Pay professional expenses by check. If it's simpler to pay for certain items in cash, take the money out of a petty cash fund—which can be replenished in accountable fashion by check.

¶ Keep carefully documented records of all income from investments. By examining items like real estate transfers, tax men uncover many deficiencies.

Hospitals Report on Status of G.P.'s

How are general physicians faring in hospitals these days? To find out, the American Academy of General Practice sent a questionnaire to 5,906 registered institutions, got back 375 replies (340 of them from general hospitals). The AAGP's findings:

¶ About half the reporting hospitals have general-practice departments.

¶ At least 90 percent say G.P.'s enjoy equal privileges with specialists.

¶ Only 2 percent have no G.P.'s on their staffs.

¶ The size of a hospital seems to have no bearing on its attitude toward G.P.'s.

Pathologist Shortage Growing Serious

The supply of pathologists is in a bad way, and it doesn't seem to be improving. What keeps young men out of the field? Various theories are advanced. One, that it is a science quite apart from clinical medicine, and so attracts only analytical minds. Two, that it is a lonely science, taking its specialists away from the brotherhood of medicine. Three, that its educational requirements are too exacting (the American Board of Pathology requires four years of approved post-graduate training). And four, the financial reward—usually a hospital salary—may not be very inviting when contrasted with the incomes of clinical men.

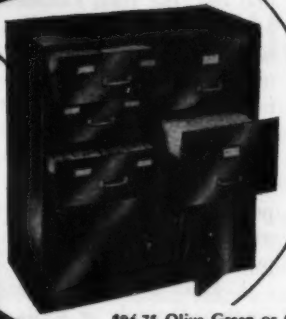
Whatever the reason, says the AMA, there aren't enough pathologists to go round. Actually, there is

NEW!

THE "DE-LUXE *Efficiency*" FILE

3 FAVORITE FILES *Exclusively* FOR DOCTORS

One of these files will suit your purposes exactly. For efficiency in your office order one today.

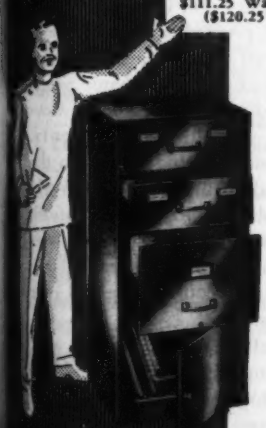


$94.75 Olive Green or Gray
($103.75 West of Miss.)

$111.25 Walnut or Mahogany
($120.25 West of Miss.)

1. The NEW "De-Luxe Efficiency" will hold ALL the records of even the busiest doctor's office. Three card drawers for 5" x 8" or 4" x 6" records. Two filing drawers for papers up to size 8½" x 14". Two roomy storage compartments with lock and key for books, drugs, etc. It is 40" high, 37" wide, 18" deep.

THE "*Giant*" FILE



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3. The "Efficiency" is the most popular of all doctors' files: a compact and economical unit. It holds 8,000 5" x 8" or 4" x 6" records, thousands of papers up to 8½" x 14". Storage compartment holds books, drugs valuables, etc. . . . under lock and key. Dimensions: 40" high, 18" wide, 16" deep.

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only about one for every four hospitals. Since 1936, when the ABP was formed, 1,658 men have been certified. But some have died and others have retired. What's more, the AMA points out, there aren't enough pathologists to staff the 1,079 approved hospitals that offer residencies and fellowships in the specialty. Each should have at least one pathologist, while the university schools need several apiece.

The annual yield from about 1,000 approved residencies should be about 200 men. But 10 per cent of the residencies have gone begging, reducing the annual output to 180 pathologists. And there is little prospect of improvement.

Something must be done, says the AMA, because hospital expansion in the armed forces, Veterans Administration, and civil life is creating new demands. Research programs also need qualified pathologists.

The AMA feels that a sales job by the medical profession, the schools, and organized medicine might bring young medical graduates into the profession. What the clinching sales points might be it does not say.

Offer Minimum Standards For Wartime Education

One of the chief lessons learned from the medical training program of World War II was that demands for speed and quantity should never interfere with quality.

How can speed and quantity be combined with quality in the event of wide or total mobilization? To find out, the Joint Committee on Medical Education in Time of National Emergency has been studying the medical schools. (The committee represents the Association of American Medical Colleges and the AMA Council on Medical Education and Hospitals.) Its recent report to the National Security Resources Board lists these nine proposals:

1. Draft laws should allow for a continued supply of well-qualified premedical students.

2. In the event of extensive mobilization, premedical training could be reduced to 90 semester hours, spread over three academic years.

3. Medical schools—not the Government—should select students. Full subsidy of students, as in the ASTP and V-12 programs of World War II, should be avoided. Instead, the Government should offer scholarships to the best candidates, or loans that could be repaid over the years.

4. Draft-deferred students, after completing interneship, should be subject to Government call in an emergency.

5. In the national interest, curricula should be revamped to put more emphasis on public health measures, including preventive medicine, epidemiology, emergency care of civilians, atomic defense, radiation protection, etc.

6. Plans should be made now to

NEW— **Chlorophyll therapy for peptic ulcers!**

CHLORESIUM POWDER

EFFECTIVE— in a recently reported clinical series*, *complete healing was obtained in 58 out of 79 cases of long-standing peptic ulcers within 2 to 7 weeks*—with new chlorophyll powder!

No special diets were required. No restrictions on smoking, alcoholic beverages or daily activity. Three out of four cases got complete symptomatic relief within one to three days!

Chloresium Powder is a nontoxic combination product designed to allow prolonged contact of tissue-stimulating chlorophyll with the ulcer crater. It also provides essential buffering and protective action.

A "Bonus" Action

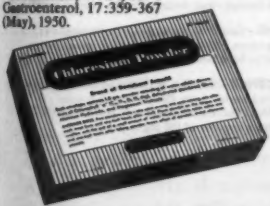
1. **Prolonged protective coating** (dehydrated powdered okra).

2. **Prompt antacid action** (alum.hydroxide, magnesium trisilicate)—no alkalosis, no acid rebound, no interference with bowel regularity.

PLUS

3. **Promotion of granulation tissue** (with nontoxic water-soluble chlorophyll).

*Offenkrantz, W. F., Rev. Gastroenterol, 17:359-367 (May), 1950.



Chloresium Powder

Natural nontoxic chlorophyll therapy for the treatment of peptic ulcers

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Chloresium Powder, in this clinical trial, demonstrated its effectiveness to the peptic ulcer patient quickly in the form of complete symptomatic relief. *It demonstrated its effectiveness to the physician, under roentgenological examination, in prompt healing of the ulcer crater—usually in 2 to 7 weeks—even in cases which had been resistant to other therapy.* (The minimum known history of the ulcers treated was two years).

The freedom from dietary and other restrictions which Chloresium Powder allows has obvious patient appeal and can greatly simplify the task of insuring patient co-operation.

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Please send trade-size sample of Chloresium Powder and reprint of the clinician's paper on chlorophyll therapy for peptic ulcers.

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and when it comes to **(human)** *Immune Serum Globulin*

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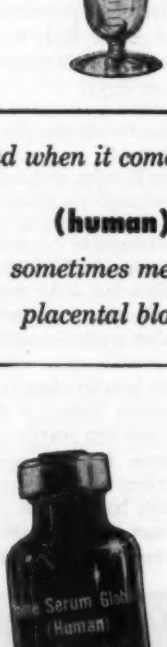
100% *venous* blood



Fresh, non-hemolyzed venous blood from paid professional donors is the sole source of Cutter Immune Serum Globulin.

... *Compare* it as a product of choice for *measles modification* and *prevention.*

CRYSTAL CLEAR—Look at the highly purified homologous protein in the Cutter vial. *See* the crystal clear, hemolysis-free gamma globulin.

MINIMAL REACTIONS—Cutter fractionation process produces a highly concentrated gamma globulin with resultant small dosage, plus crystal clear purity to hold reactions to a minimum.

STANDARDIZED POTENCY—Each lot of Cutter globulin is made from human venous blood pooled from 4500 male and female donors to assure consistent anti-measles activity—providing a constant gamma globulin content of 160 mgm. per cc.

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CUTTER Immune Serum Globulin

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Producers of concentrated 2.5 cc. Hypertussis®—specific for passive immunity against whooping cough

expand schools so they can take in more students without lowering standards. Annual admissions have increased from an average of 6,000, before World War II, to a current 7,000. But a further increase will be needed. More money will be needed to build and operate schools; this problem of funds should be studied separately.

7. Teachers will have to be obtained for expanded facilities. The committee estimates that one full-time instructor (or the equivalent in part-time teachers) is needed for each four students in the first and second years; one instructor for each three students in the third and fourth years.

8. Interneship should be at least twelve months long. The nine-month interneships of World War II were unsatisfactory. The saving in time resulted in poorer training.

9. The nine-month residency (nine to eighteen months in some cases) was likewise unsatisfactory.

Eve Puts On Medical Striptease in Ohio

"Eve," a transparent plastic model of a woman, is on public display at the Cleveland Health Museum. All anatomic parts, including bones, main organs, arteries, veins, nerves and the lymphatic system have been reproduced in natural color. A lighting system illuminates each in sequence while "Eve" describes her innards to the audience via a loudspeaker system.

The model, fifth of its kind, is similar to the "Camp Woman" (now in Chicago's Museum of Science and Industry) except that the Camp Woman is mute and has no nervous system. Eve was built in Germany by Franz Tschackert and his son, noted medical artist-technicians. The model has been insured for $15,000 by the Cleveland Health Museum.

Calls Solo-Doctor Care Inferior to Group Care

U.S. medicine is not nearly so effective as it might be. And it won't improve much while it's in the hands of solo physicians. What's needed is group practice on a grand scale. On top of that, incompetence must be weeded out of the profession by a more rigid licensure system. These are the views of Dr. William Dock of New York State's College of Medicine in Brooklyn (formerly Long Island College of Medicine).

Solo physicians aren't capable of using the modern tools at their command, Dr. Dock maintains. "Our profession has resisted the twentieth century more successfully than the grocers have resisted the chain stores or the cartwrights resisted the automotive industry. But in the end obsolete methods must be replaced or the whole system will be swept away. Doctors *must* work together in teams, varying in size and complexity to suit their community." [*Turn page*]

The family doctor of the future, Dr. Dock believes, will focus the work of his colleagues in group practice. His role will be in "the preventive phase, the prompt management of readily controlled illness, and the early detection of the need for special study and intervention.

"In the end, the most effective service will have to be provided by competing teams of doctors and by competing clinics. Some teams may have only three or four members, others may have hundreds. Many will be developed around our hospitals, medical schools, and industrial medical centers. Others must be fashioned to meet community needs."

Medical societies should put their weight behind groups and not leave the job to politicians, the educator declares. Such action, he says will not only promote good medical care but will "avoid the dead bureaucratic mediocrity accepted in Great Britain . . . Eventually, the demagogic movement for Federal health

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for greater patient comfort, prescribe Desitin Hemorrhoidal Suppositories in hemorrhoids (non-surgical), pruritus ani, uncomplicated cryptitis, papillitis, and proctitis.

℞ Composition: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. No narcotic or anesthetic drugs to mask rectal disease. Boxes of 12 foil-wrapped suppositories.

soothing • protective • lubricant

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insurance will become an unhappy memory, like that of the occasion when the Army was ordered to fly the mail."

Each year, he says, more and more patients are dying because they entrust their cases to solo doctors rather than to groups that could save them.

Incompetency in the specialties is killing countless others, he contends. "Some progress in raising standards has come from physicians, but it is purely voluntary. One could imagine the uproar if licensing of airplane pilots were left to pilots' clubs. But few are concerned about the self-appointed specialty boards in medicine or surgery. The public is not protected from incompetent doctors by any Government agency. This situation will become more serious as the gap between good and poor medical care widens, and the number of physicians increases. The quality of their service must, in future, be controlled more rigorously."

Is It True What They Say About Women M.D.'s?

Women doctors still have their problems. The chief one is certification. Hospitals take a dim view of female candidates for residencies, figuring that many will desert medicine for marriage, so why waste time on them? Knowing what they're up against, relatively few women M.D.'s attempt board certification. Those who do usually go in for obstetrics, gynecology, or

"Did nature intend the pregnant woman to wear a support--?"

Spencer provides "hammock-like" support for the growing uterus, comfort and protection for back and breasts.

No **- just as nature did not intend her to require additional nutrients, hormones, stimulants or sedatives! But under today's stresses and strains, nature's intentions often fall short, so *proper* supports - like medicines - have their place in modern therapy.**

Spencer Supports will provide greater therapeutic benefits for your *average* antepartum-postpartum patients - as well as for those with backache or other symptoms - because:

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We invite your trial of Spencers for men and children, too.

MAIL coupon at right — or PHONE a dealer in Spencer Supports (see "Spencer Corsetiere," "Spencer Support Shop," or Classified Section) for information.

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pediatrics. And they're finding those specialties crowded.

The American Medical Women's Association has been trying to solve the problem, with poor success. It asked the five women's hospitals in the U.S. if they would develop new post-graduate programs, especially in plastic surgery and urology. The replies have been discouraging.

Now the AMWA would like to get at the root of the marriage issue. No one, it says, has ever tried to find out what proportion of woman-M.D.'s quit the profession for housekeeping. So it has invited "some disinterested agency, such as the Commonwealth Fund," to conduct a statistical survey.

Ties Hospital Waste To Government Aid

Extravagant waste is the likely result when hospitals are built with public funds, says the California Medical Association. It cites an institution that recently built a twenty-eight-bed addition with a complete surgical-obstetrical unit costing $25,000. The unit will stand idle most of the time, since the hospital has only 250 deliveries a year, about 5 per cent of them by Caesarean section.

In another hospital built with government money, says the CMA, a complete laundry was installed. It has never been used, for its operating cost would exceed ordinary commercial laundry charges two-and-a-half times.

The picture changes when ho-

Big Hit With Babies—

Heinz Strained Chicken Soup

Rich with Tender Chicken and Golden Egg Noodles

YOU'LL find that the babies in your care really enjoy Heinz Strained Chicken Soup! All the goodness of old-time chicken soup is captured in this favorite especially adapted for babies! Made from tender, plump chickens, rich cream, golden egg noodles and choice vegetables, it's also a good source of riboflavin. Recommend Heinz Strained Chicken Soup for the enjoyment and nourishment of your youngest patients!

HEINZ makes a complete line of baby foods for your youngest patients! These quality products include—

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Strained Baby Foods
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—every one outstanding for flavor, color and texture!

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CEREALS • MEATS • VEGETABLES
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57

pitals are built with private funds, says the association. It cites a twenty-five-bed structure that was designed for maximum economy and efficiency, and has been operated in the black for more than a year.

The CMA believes that public funds should be used for hospital construction "only as a last resort after all sources of private funds have been investigated and found unavailable."

Local Newspaper Ads Tell Doctor's Side

A series of newspaper ads—talking the layman's language—has made new friends for doctors and for the Lehigh County (Pa.) Medical Society which publishes them. Pointing out that "free" Government medical care is "only as free as taxes," the ads stress that *really free* care is provided by doctors for those who cannot pay. The confidential relations between physician and patient is underscored,

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

Medical Economics, Inc.
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to prescribe **SIMILAC**

simply add one measure of Similac to two ounces of water to yield two ounces of normal formula of 20 cals/oz

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to prepare **SIMILAC**

simply instruct mother to float the prescribed quantity of Similac on previously boiled water and stir

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to digest **SIMILAC**

for { the proteins have been so modified
the fats so altered
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that there is no closer equivalent to human breast milk than

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for term and premature infants throughout the first year of life whenever breast feeding must be supplemented or replaced. Similac has the same zero curd tension as human breast milk.

SIMILAC DIVISION M & R DIETETIC LABORATORIES, *Columbus 16, Ohio*

say the ads, with no duplicate records for politicians to pore over.

Readers are coached in the art of getting along with their doctor: "For 2,000 years the code of medical ethics has placed the welfare of the patient above every other consideration. American doctors not only subscribe to that code—they live by it. But be fair to your doctor as he is to you. Don't put off explaining your financial circumstances until after you receive your bill."

Other ads explain the long, costly education of a physician; how readers can get a doctor in an emergency; how medicine is organized, and why; and how the American system has evolved preventive medicine, ending the days "when every undertaker had a white hearse as well as a black one."

Get Badly Handicapped Into Jobs: Rusk

Industry faces a tough problem: the supply of manpower is getting tighter while the demand remains high. In 1940, 8 million persons were unemployed; in 1950, only 2.5 million. With continued prosperity and the prospect of increased war production, the manpower barrel will soon be emptied. Then where can industry find the millions of workers it will still need?

Dr. Howard A. Rusk, chairman of the Health Resources Advisory Committee of the National Security Resources Board, emphasizes the big reservoir of labor left among

To be specific...

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CREAM *with 9-Aminoacridine*

Here are the facts! **A.V.C. IMPROVED is specific for the treatment of Trichomonas vaginalis vaginitis. This statement is substantiated by cumulative clinical evidence.**

For example... **Hensel* reports: "Symptomatic and bacteriologic cures were obtained in all of the 39 patients with Trichomonas vaginalis vaginitis, treated with A. V. C. IMPROVED. It was equally effective in monilial vaginitis and in nonspecific vaginitis."**

*Hensel, Hubert A.: Postgraduate Medicine, 4:293-296, October, 1950.

Available in 4 oz. tubes, with or without plastic applicator.

The National Drug Company *Philadelphia 44, Pa.*

More than half a century of service to the medical profession

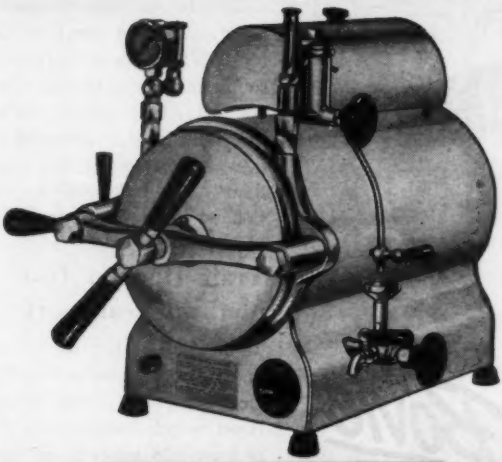
those who have major physical disabilities or chronic illnesses.

People with minor handicaps can easily be fitted into jobs, Dr. Rusk says, pointing out that 90 per cent of them are employed now. "The great untapped source of manpower," he adds, "is the estimated 1,500,000 to 2,000,000 persons with severe . . . disabilities who could become employable [with] modern rehabilitation and retraining. Moreover, there are other millions of chronically ill who are potentially productive if given adequate training."

Dr. Rusk calls for the immediate start of a national training program to operate in all major industrial centers. Tests show, he says, that older persons produce as well as younger ones, and that "new, scientific tools have been developed that will allow us to utilize the handicapped to their full capacities in the battle of production."

Asks AMA to Talk the 'Public's Language'

If the AMA "comes down out of the clouds and talks the public's language," its education campaign will be a greater success, says a reader of the Los Angeles Times. Americans are not interested in idealistic arguments against socialism, writes Lucy Brokaw Schafer. "Mr. and Mrs. Average Citizen are engrossed with the problems of eking out an existence in the face of higher taxes and higher prices... The way to sell the so-called 'com-



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Death on Bacteria

NO MATTER how minor the surgery you may perform in your office, you face a grave responsibility. You never can tell when the blood stream of a patient carries spore-bearing bacteria. Consequently there is always the danger of cross-infection when an instrument touches any incision. That calls for the safety of hospital sterilization in your office . . . certain destruction of the toughest bacteria. For such safety, the Pelton HP Autoclave is the perfect answer. It is compact, fully automatic. See it at your dealer's or write for literature.

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mon man' is through his pocketbook. I don't mean in billions of dollars for an over-all cost of the program. Get it down to his own terms. The Hoover Commission has found that it's a lot more convincing to say that adoption of its findings will mean a saving of $25 for every man, woman, and child . . . than to say that it will save the nation $4 billion annually."

Train Disaster Tests Medical Teamwork

Medical disaster units showed "magnificent teamwork" in handling victims of the Long Island Rail Road wreck (seventy-eight killed, at least 328 injured) in Richmond Hill, N.Y. on Thanksgiving Eve. That's the praise handed them by New York City's Commissioner of Hospitals, Dr. Marcus D. Kogel. He directed their efforts through twenty-four sleepless hours.

"If anything," says Dr. Kogel, "we had too many people and too much equipment for a disaster of that size. We had to send home half the doctors who answered our first calls."

What can other disaster units learn from the Long Island crash? "Communication was our big trouble," says Dr. Kogel. "We had a hard time getting messages from one casualty station to another. We finally had to use runners. What we really needed was a supply of walkie-talkies.

"Getting word from the casualty stations to the hospitals was an-

for relief of
CONSTIPATION *and* HYPERACIDITY

For more than 75 years, Phillips' Milk of Magnesia has been generally accepted by the medical profession as a standard therapeutic agent for constipation and gastric hyperacidity.

As a laxative — Phillips' mild, yet thorough action is safe for both adults and children.

As an antacid — Phillips' affords fast, effective relief. Contains no carbonates, hence produces no discomforting flatulence.

DOSAGE:
Laxative: 2 to 4 tablespoonfuls
Antacid: 1 to 4 teaspoonfuls, or 1 to 4 tablets

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other weak link. A few ambulances at the scene had two-way radios, but when a million things are happening at once, doctors need their own."

Blood supply? No problem. "Our hospital staffs had difficulty handling the thousands of donors who showed up," Dr. Kogel comments. "Actually, our blood supplies were more than adequate, but some unofficial appeals had been made despite that. The response, in any event, was certainly heart-warming."

Does Dr. Kogel feel the wreck experience indicates medical readiness for an atomic attack? "There's no comparison between the two types of disaster," he says. "Casualties from an A-bomb explosion might be 500 times greater. But if medical workers respond with the spirit I saw at Richmond Hill, tens of thousands of lives will be saved."

Says 'Stupidity' Forced Draft of Physicians

Why was it necessary to draft doctors for the armed forces? Why wouldn't they volunteer in sufficient numbers? Probably because they were aware of the "frustrations, stupidities, and inefficiencies" of the medical departments during World War II. So speaks Dr. Loyal Davis through the editorial page of the Los Angeles Times.

"It is difficult," he says, "for the civilian doctor to understand why the Navy, Army, and Air Force insist upon having separate and di-


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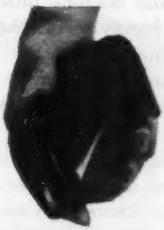
tinct hospitals under their own command. It is hard for the surgeon to understand why a fractured femur, regardless of whether it was sustained in ground combat, on a ship, or in an airplane accident, should not be treated in the same manner in one hospital to which any soldier, marine, sailor, or airman might be sent."

Dr. Means Claims AMA Talks, Doesn't Act

Agitators for socialized medicine are making the most of "The Doctors' Lobby," an article by Dr. James Howard Means, professor of clinical medicine at Harvard. Originally published in the Atlantic Monthly, the article was read into the Congressional Record by AMA-hating, lame-duck Rep. Andrew J. Biemiller (D., Wis.).

Dr. Means damns the AMA, Whitaker & Baxter, and Blue Shield plans. "The Whitaker & Baxter campaign," he says, "is the same old Fishbein line, which has evolved approximately as follows: Down with compulsory health insurance—compulsory health insurance is socialized medicine—socialized medicine is state socialism—state socialism is eternal damnation, and so on."

Service-type health insurance plans sponsored by medical societies have "glaring deficiencies," Dr. Means contends. "For one thing, they probably do not cover more than one sixth of the average fam-



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Ophthalmoscope details: National's No. 40 with one finger control for apertures, dioptres, light and with brilliant light beam and three apertures plus red-free filter; dioptric range —20 to +25. With smooth precision action and precision vision. Head . . . metal, wafer-thin, light, black.

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ily's annual doctor's bills, so that they are hardly more than a token of economic aid.

"In this emergency I consider that organized medicine has failed dismally. It cries now for voluntary health plans but does little actually to produce them. The record shows that when others have sought to do these things organized medicine has obstructed them. A learned profession has sunk, or has been dragged, in its political sphere, to a distressingly low level."

Would Use Boy Guides For A-Bomb Victims

Panic will be one of the worst by-products of an atom-bomb attack, says Dr. Leonard A. Scheele, surgeon general of the Public Health Service. It will arise, he believes, when hysterical victims try to find medical aid. Then, he says, medical and social workers can be of more value than the police.

Dr. Herman E. Hilleboe, New York State Commissioner of Health, also calls for realistic training of civil-defense squads. In England, he says, former army men act as bomb victims during drills, and cry for help from "ruined" buildings. Rescue squads then get real practice in removing them and carrying them to first-aid centers.

"It probably will be effective to make use of boys between 12 and 15 as messengers and guides for the hysterical," says Dr. Hilleboe, "Terrified people cannot be forced to do things by policemen."

"Upper Respiratory"—

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For childhood colds, sore throats and other febrile or painful conditions, Aspergum provides acetylsalicylic acid in easy-to-take, deliciously flavored, *chewing gum form.*

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Just 3½ grains of acetylsalicylic acid per tablet —a dosage and form uniquely fitted to childhood requirements. Promoted ethically.

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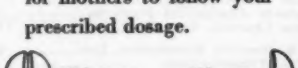

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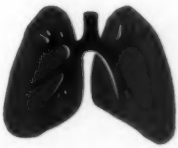

By Lung:
Potent penicillin G aerosol solutions can be prepared readily by dissolving PENALEV tablets in water or normal saline.

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